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

In the Matter of:	**Docket No. 13-0293**
Seattle Children's Hospital Appeal of OIC's Approvals of HBE Plan Filings.	**SEATTLE CHILDREN'S HOSPITAL'S RESPONSE TO JOINT MOTION IN LIMINE OF PREMERA, OIC AND BRIDGESPAN REGARDING POST-APPROVAL MATTERS**

I. SUMMARY

The Joint Motion seeking to exclude from this hearing all evidence regarding "what happened after July 31, 2013" should be denied for the following reasons:

(1) The motion fails to identify the evidence it seeks to exclude with specificity. The reason for the lack of specificity is obvious. On July 31, 2013, the OIC approved intervenors' QHPs based on its mistaken assumption that SCH was in-network. At the same time, it disapproved QHPs submitted by CCC and Molina because they did not include pediatric hospitals.[1] CCC and Molina appealed; the CCC appeal went to hearing at the end of August. At the CCC hearing, the OIC staff strenuously asserted that the plan's networks were inadequate without pediatric hospitals, also took the position that out-of-network arrangements, including single case agreements, were not only inadequate, but illegal.[2] Then, at the about the same time as its former Hearing Officer ruled in favor of CCC on the single case agreement issue, the OIC

[1] See Ex. 106 attached (OIC Press Release).

[2] See Ex. 107 attached (OIC's Hearing Brief in CCC).

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ORIGINAL

realized its mistake with respect to intervenors' networks. At that point, notwithstanding the fact that Commissioner personally moved for reconsideration in CCC arguing that the use of single case agreements were illegal,[3] the OIC decided that the BLE process that Premera proposed to use was an adequate substitute for in-network status. This decision is, in fact, the key issue in the case. Otherwise, SCH should win simply on the basis that the OIC made its decisions with respect to intervenors' QHPs based on a mistaken assumption about SCH's status.

(2) Evidence regarding harms to SCH's patients and SCH is relevant to establish standing, as required under RCW 48.04.010, a matter that the intervenors have challenged and continue to challenge in their hearing briefs.

(3) To the extent that the OIC and intervenors ask for review of the decision based on information known on July 31, 2013, SCH must prevail as a matter of law, since the OIC's decision maker Deputy Commissioner Molly Nollette has testified that, as of July 31, 2013, she believed that SCH was in-network as to the Premera/LifeWise and BridgeSpan QHPs (Qualified Health Plans or Exchange plans), even though the OIC has since admitted that was not true.

(4) Post-approval harm to plan enrollees and providers is directly relevant to the issue whether the networks were in compliance with the ACA and state law network adequacy requirements to begin with, and to whether the plans as they operate are adequate.

(5) The motion is untimely. The Under the Pre-Hearing Order in this matter, motion practice is governed by KCLR (b)(4)(a), which requires six court days notice for non-dispositive motions, and allows 3.5 court days for response. In order to disrupt SCH's hearing preparations, intervenors purposefully sat on this and their other motions in limine until after the August 8 deadline for such filings. For this reason alone, the motion should be denied.

[3] Ex. 108 attached (Commissioner's motion for reconsideration in CCC).

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II. ARGUMENT

A. The Motion Fails to Identify the Evidence It Seeks to Exclude.

As an initial matter, a motion in limine must identify the evidence sought to be excluded "**with sufficient specificity** to enable the trial court to determine that [the] evidence is clearly inadmissible."[4] Exclusion of evidence in limine is inappropriate if specific evidence is not identified.[5] The motion seeks to exclude "testimony and documentary evidence concerning a number of matters that post-date the OIC's decision," but fails to identify that evidence with specificity. The motion does not identify which witnesses (other than the two patient family witnesses Alexandra Szablya and Jenni Clark), and which exhibits it seeks to exclude.

Further, as set forth in the introduction, a key—if not the key—issue in this appeal is the validity of OIC's revisionist position that using single case agreements and the like, including so-called "Benefit Level Exceptions," as a means of providing Essential Health Benefits and providing access to Essential Community Providers, is consistent with the ACA and state network adequacy principles. The OIC's post-approval statements, specifically including its flip-flop on the issue, subsequent actions and inactions, as well as the impact of those actions, are directly relevant to these issues.

B. Evidence of Harms to SCH Patients and SCH Is Relevant to RCW 48.04.010 Standing.

SCH has standing to pursue this action because SCH and its patients have been "aggrieved by any act … of the commissioner." RCW 48.04.010. The issue of standing, already extensively briefed in the hearing briefs and earlier, remains for resolution at the hearing. SCH

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[4] *Fenimore v. Donald M. Drake Const. Co.*, 87 Wn.2d 85, 91, 549 P.2d 483 (1976) (emphasis added). *See, e.g., Douglas v. Freeman*, 117 Wn.2d 242, 255, 814 P.2d 1160 (1991); *Amend v. Bell*, 89 Wn.2d 124, 130, 570 P.2d 138 (1977).

[5] *See, e.g.,* Tegland, 5 Wash. Prac., *Evidence Law & Practice* § 103.4 (5th ed. 2012) ("If the motion is to exclude evidence, it should describe the evidence with sufficient specificity to enable the court to determine its admissibility"); 30 Wash. Prac., *Wash. Motions in Limine* § 1:4 (2012) ("**Motions in limine may be inappropriate where it is difficult to specify exactly what evidence is the subject of the motion**") (citing *Fenimore*) (emphasis added); Tegland, 5 Wash. Prac., *Evidence Law & Practice* § 103.5 (5th ed. 2011-12) ("The motion may be denied if it is too vague or too broad, or **if the legal issues are inadequately briefed**") (emphasis added).

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can and must present evidence regarding how it and its patients have been "aggrieved." As the motion in limine notes, these injuries occurred during 2014. The injuries did not and could not have occurred before the July 31, 2013 OIC decisions, although they were foreseeable consequences of the OIC's errors.

C. Review Based Solely on Pre-Approval Evidence Would Invalidate the OIC's Decisions.

To the extent that this review was limited to the information that the OIC relied on at the time of its July 2013 approval decisions, it would be based on false information. The BridgeSpan and Premera/LifeWise QHPs did not include pediatric hospitals in their networks at the time of approvals, but the responsible party on the Commissioner's staff – newly appointed Deputy Commissioner Molly Nollette – erroneously believed they did.[6] This mistaken belief was critical to the decision-making: the OIC at the same time disapproved the CCC and Molina networks specifically on the basis that they failed to include pediatric hospitals. Only in hindsight did the OIC realize its error, when it then cobbled together a new rationale to defend what it had already done. This review can and must consider this evidentiary record.

D. Post-Approval Evidence Is Relevant to the Review of the ACA and State Network Adequacy Requirements.

The state's network adequacy rule requiring health plans to "maintain" an adequate network[7] also requires the OIC to engage in continuing oversight in order to determine the

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[6] 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?
> Q. Yeah.
> A. I actually thought they were in network. Surprised me.

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

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ongoing adequacy of plan networks. Recognizing that health plan networks are not fixed in time, the OIC's rules require health plans to submit monthly updates of their network databases ("Form A filings") in order to engage in ongoing oversight,[8] and also performs ongoing market analysis and market conduct oversight.[9] For the OIC to now assert in this motion that its own decision-maker should refuse to consider current information regarding plan operations—and to specifically ask the decision-maker to refuse to hear the testimony of health plan enrollees—is antithetical to the OIC's own market oversight duties.

ACA's essential health benefits and essential community provider network requirements are designed to complement the ACA's prohibition on discriminatory benefit design that discourages enrollments of certain types of patients.[10] The fact that patients are in fact being discouraged from enrolling is relevant to compliance with these ACA requirements. The motion also presumably seeks to shield the decision-maker from considering the fact that the OIC was unaware at the time of its approvals of the fact that its use of the CMS ECP "tool" resulted in a determination that the Premera/LifeWise network met the ECP requirement as to King County solely because it included Snoqualmie Valley Hospital in its network, a hospital with no pediatric capacity.

Post-approval evidence is specifically relevant here with regard to the accuracy of the information that the OIC relied on in its July 2013 approvals. As the motion asserts, and the

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[8] RCW 48.44.080.

[9] RCW 48.37; WAC 284-37.

[10] 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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hearing briefs repeat, the OIC's approval decisions relied upon assurances from Premera/LifeWise and BridgeSpan that enrollees would obtain required benefits at an in-network cost share.[11] The post-approval evidence that SCH recounted in its hearing brief demonstrates that this is not occurring. Enrollees are not obtaining the required benefits, and remain subject to balance-billing. The OIC can and must consider this information. If its July 2013 decisions relied on false premises, then its decisions cannot stand.

E. The Motion Is Untimely.

As explained above, this motion could and should have been submitted by August 8th, which would have allowed SCH the appropriate number of days to prepare a response. Intervenors have not provided the slightest excuse for this act of gamesmanship.

F. The OIC and Intervenors Misstate the Controlling Legal Standards.

The motion's assertions regarding the legal standards relevant to this hearing, while not relevant to this motion in limine, are incorrect. As has already been established, the Hearings Unit in this action will be rendering "a final decision on behalf of the OIC."[12] This is not a judicial review under the APA from a final agency decision.[13] The motion's assertion that a deference standard applies cites solely to federal decisions. Even in the context of a judicial review, state courts do not employ a deference standard to review of agency decision making, particularly on issues of law and statutory interpretation.[14]

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[11] *See* Motion, at 2 ("the OIC … approves a health **if it provide access to covered services at in-network cost**") (Emphasis added).

[12] Order on Pre-Hearing Conference, filed June 12, 2014.

[13] RCW 34.05.570.

[14] *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").

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III. CONCLUSION

For these reasons, the motion should be denied.

DATED this 14th 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 hand delivery on today's date addressed to the following:

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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 14th day of August, 2014.

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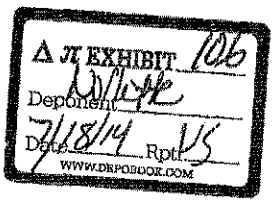
3/30/2013



Kreidler achieves settlement with two ıealth insurers – approves 10 ıdditional Exchange options for ;onsumers

LYMPIA, Wash. – Insurance Commissioner Mike Kreidler has reached settlements with ommunity Health Plan of Washington and Kaiser Foundation Health Plan of the Northwest ıd approved their 10 plans for sale in Washington's Health Benefit Exchange, the /ashington Healthplanfinder.

onsumers in Washington will now have 41 choices in the Exchange when open enrollment ægins Oct. 1. Community Health Plan of Washington (CHPW) will have three plans /ailable in 26 counties.

aiser will offer an additional seven plans in Clark and Cowlitz counties.

reidler said the additional 10 plans meet the same high standards held for the other ɔproved companies. They also ensure continuity of care for Medicaid enrollees and create ıore competition in the marketplace.

he Exchange set an initial July 31 deadline for the Insurance Commissioner's review and ɔproval of plans for inclusion in the Exchange, where subsidies for health coverage will be ffered as part of the federal Affordable Care Act.

Ve had 31 health plans approved by the Exchange's deadline. Washington consumers ɔw have an additional 10 quality plans to choose from," Kreidler said. "We took the initial eadline seriously, but we also followed our own legal process and it worked. The xchange cannot delay any further. It must take action and approve these plans by Sept. 5."

ept. 5 is an extended federal deadline granted to Washington's Exchange to approve lans.

reidler said that he made the tough decision to disapprove some plans on July 31 because e did not believe they met rigorous state and federal standards. He said he also knew he ould take some heat for standing up for consumer protection.

've worked for meaningful health reform my entire career," he said. "I'd much rather face ıe political fallout that my decision may have caused than know I set consumers up to be armed in the future by plans that don't deliver what they promise."

...nated Care Corporation, Kaiser, and CHPW – appealed Kreidler's decision. olina later dropped its appeal, but refilled it last night.

ppealing opened the door to settlement. Kreidler began discussions with only those mpanies he believed could make the necessary fixes in time before the federal deadline Sept. 5.

knew it would be a serious challenge for both companies and my office to reach a iccessful settlement, given the time constraints," Kreidler said.

ne agreements required the companies to revisit and fix very specific issues identified by e insurance commissioner's office during the original review process. Any deviation or nission would have meant failure.

pecifically, CHPW had to agree to drop its proposed two-tier pricing structure. Its intention as to provide a zero co-payment option at community clinics. Unfortunately, under 'ashington state law, charging different co-pays for the same type of provider can look like scrimination, steering lower-income residents to only certain providers. CHPW fixed this sue.

ne Insurance Commissioner will work with the company over the next year to explore how help it meet its goals within the law. The revised final plans resulted in a 1 percent to 2 ercent rate increase.

aiser had to correct its rate information so that it was complete and matched other formation it had filed. It also had to ensure that all of its plans it said were compatible with ealth Savings Accounts met federal standards.

wish I could've entered settlement talks with all of the companies that appealed," Kreidler aid. "Unfortunately, I believed the substantial issues facing Coordinated Care could not be ldressed in time to meet the Sept. 5 deadline."

oordinated Care had more than a dozen serious issues, including:

Lack of legal medical provider contracts with a children's hospital.

No guaranteed contract with a burn unit that would handle initial care of a patient. While the company stated it would create spot contracts with providers on a case-by-case basis, such arrangements fail to guarantee coverage and could expose consumers to serious financial risks they never expected.

During this process, our goal has never waivered – to give Washington consumers as any choices of high quality health insurance plans as possible," Kreidler said. "I'm very eased with our thorough reviews and of the 41 plans we've approved. Our foremost esponsibility is to protect consumers. Now, it's up to the Exchange to approve these plans nd for everyone to get ready for Oct. 1."

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elease No.13-23

MIKE KREIDLER
STATE INSURANCE COMMISSIONER

STATE OF WASHINGTON

OFFICE OF
INSURANCE COMMISSIONER

Phone (360) 725-7000
www.insurance.wa.gov

In the matter of:

COORDINATED CARE CORPORATION,

a licensed Health Maintenance Organization.

No. 13-0232

OIC'S HEARING BRIEF

INTRODUCTION

Coordinated Care Corporation ("Coordinated Care" or "the Company") has filed forms, rates, network and binder for its proposed Washington Health Benefit Exchange Individual market products. At the hearing on this matter, OIC will show that these filings violate both Washington law and the federal Affordable Care Act ("ACA") in numerous ways. We will demonstrate that Coordinated Care was notified of these deficiencies and given extraordinary assistance and opportunities to correct them. It failed to do so. Its filing was therefore closed and disapproved by the OIC on July 31, 2013. Coordinated Care has requested that the Hearing Officer reverse that decision and order OIC to approve the filings for sale on the Washington Health Benefits Exchange.

The OIC will demonstrate the following at hearing:

1) That the Agency took extraordinary steps to assist carriers to prepare for ACA implementation and Exchange Filings, and provided special assistance to Coordinated Care in particular. However, Coordinated Care routinely failed to cure problems with filings, and did not follow specific direction from the OIC to help them. As a result, their filings on July 31 contained significant errors and omissions and were disapproved; and

2) That the network filed by Coordinated Care was inadequate, and did not comply with Washington law, exposing consumers to the risk of balance billing; and

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3) The Health Benefit plan filed by Coordinated Care did not comply with several state and Federal laws.

4) That it correctly disapproved Coordinated Care's filings on the deadline of July 31, 2013.

OIC believes that it lacks the authority to extend the deadline or to approve Coordinated Care's proposed exchange plans, because it believes those plans are not compliant with the law.

Because OIC will demonstrate at hearing that the violations embodied in the proposed product would mislead and endanger consumers, and because OIC does not have authority to grant the relief Coordinated Care seeks, OIC urges the Hearing Officer to uphold the disapproval of this filing.

ARGUMENT AND AUTHORITY

I. The OIC Took Extraordinary Steps To Prepare Carriers For ACA Implementation And Exchange Filings, And Devoted Extraordinary Time And Resources To Coordinated Care In Particular. Even With This Support, Coordinated Care's Filings Contained Serious Errors That They Did Not Cure By The Deadline Of July 31, 2013.

The Affordable Care Act ("ACA"), otherwise known as health care reform, was passed on March 23, 2010. Beginning even prior to its passage, OIC began planning for its role in implementing this historic legislation. OIC knew it would be difficult for this Agency, as well as everyone else in the Washington insurance industry, to learn and implement the new requirements. In particular, Insurance Commissioner Mike Kreidler and his staff recognized the challenges insurance carriers would face in designing products that would meet the new requirements. The ACA requires that all health plans be actuarially uniform, conforming to one of four "metal levels," a concept never before seen in the industry. The ACA also requires inclusion of a full spectrum of "Essential Health Benefits." While certain benefits had been required by state law before, this was a new set of "mandates" carriers had to meet. Moreover, the plans at issue were to be sold in a "Health Benefit Exchange," another new concept never seen before in this industry.

OIC recognized that even the most experienced Washington carriers would be challenged to adapt to this new reality. The agency, therefore, began an intensive program of education sessions for carriers about the new benefit requirements and the new methods of filing products for approval. Coordinated Care Corporation ("Coordinated Care") attended those training sessions.

In addition, OIC recognized that carriers, such as Coordinated Care, who were new to the commercial health insurance market would face the added challenge of learning that business, and the law that governs it. Coordinated Care is one of several carriers whose only experience is in providing Medicaid services: a radically different world from designing and administering a commercial health insurance plan. The Medicaid program is designed by the purchaser – the Washington HealthCare Authority – which provides the bidders every piece of information about the product (price, benefits, service area). The bidders simply build that product. A commercial health insurance product is designed entirely by the carrier, and each carrier's design is unique. OIC simply ensures that these designs meet the requirements of state and federal law. For that reason, OIC devoted extra time and resources to these carriers in order to ensure that they got the answers they needed to succeed.

Finally, Coordinated Care faced a challenge that no other carrier who filed Exchange products faced: it had never done business in Washington before. Coordinated Care was awarded its first Medicaid bid in July, 2012, in the middle of the time period OIC estimated it would take for even experienced Washington commercial carriers to design Washington Exchange products. That meant that not only would Coordinated Care be new to Washington law, it would be new to the System for Electronic Rate and Form Filing ("SERFF"), the electronic filing system designed by the National Association of Insurance Commissioners and used by Washington. Being aware of that, and committed to ensuring that every plan that sought to sell products in the Exchange was successful, OIC devoted more time and resources to Coordinated Care Corporation than to any other company who filed an Exchange product.

Coordinated Care struggled with the requirements of its filings from day one. While every company had a tough time navigating the new ACA landscape, Coordinated Care made so many mistakes – almost certainly attributable to its newness to commercial health insurance and to Washington law – that it was

unable to complete an error-free filing in time for its products to be approved for sale on Washington's Health Benefit Exchange in 2014.

Coordinated Care lost 3 months of time at the outset by failing to correctly identify what type of company it was under Washington law. Carriers must identify what type of company they are to the OIC when seeking a Washington license: a disability insurance carrier or a Health Maintenance Organization ("HMO"). Disability carriers have a significantly different business model from HMOs. The difference affects Company activities, including the type of filings they must submit, because each type of company is structured differently and is subject to a separate body of law. A disability carrier insures its members against the risk that they will need health care. When they do, the members must submit claims and the carrier determines whether those claims are covered. A HMO is a health care delivery system that provides services through practitioners and facilities under contract with the HMO.

Unfortunately, on April 4, Coordinated Care initially filed as a disability insurance carrier (Coordinated Care is actually an HMO). OIC was forced to disapprove the filing, and specifically instructed Coordinated Care to re-file as an HMO.

On May 2, a month later, to OIC's dismay, Coordinated Care filed again as a disability insurance carrier. OIC staff became concerned about the passage of time. Rather than simply disapprove, staff reviewed the incorrect filing to the extent they could so that Coordinated Care could resolve any identified problems in its necessary re-filing as an HMO. OIC disapproved the second filing and provided a detailed disapproval letter on May 10, 2013.

In addition to providing a letter, then-Deputy Commissioner for Rates and Forms Beth Berendt personally called the CEO of Coordinated Care to provide information about the problem, so that Coordinated Care could correct it. OIC staff, including Deputy Commissioner Berendt, Senior Plan Analyst Jennifer Kreitler, and Actuary Lichiou Lee also met in person with Coordinated Care representatives to discuss the problem and the preliminary issues they had seen in the review they were able to do of the second filing.

OIC staff saw myriad serious problems with this second filing. One of the biggest and most immediately recognized was that this second filing included "variability." Variability occurs in a health care contract when a carrier inserts brackets in the contract language, with a request to fill in the brackets with one of two (or more) options. This allows the carrier to negotiate benefit options with the purchaser. Along with the contract, the carrier provides the exact language for the options from which the purchaser can choose.

OIC had stressed repeatedly in the training sessions for filers that both Washington law and the ACA forbid variability in individual plans. This prohibition exists for two reasons. First, carriers are required to use community rating for individual plans. Community rating means calculating premiums based upon the risk factors applicable to all persons within the individual insurance market population, not those of any one person. This is a preventive measure to protect people who require expensive health care from being charged unaffordable rates. Plans must be standard in order to be community rated, because in order to charge the same premium, carriers must be pricing the same benefits. That was Washington state law even before the ACA. Second, the ACA now prohibits variability in the Exchange because all Exchange plans must meet one of the four "metal levels" in order to allow the "apples to apples" comparison for which the Exchange was designed.

The inclusion of variability in Coordinated Care's filing was a fatal error that would have required disapproval, even if the filing had been structured as an HMO product. OIC notified the company of this problem in its disapproval letter, phone call, and in-person meeting with Coordinated Care. OIC also notified Coordinated Care of the other problems staff had been able to see in its second filing.

Coordinated Care filed a third time on June 4, 2013; this filing failed to correct the variability error which necessitated yet another disapproval of the filing. However, consistent with its determination to identify problems as quickly as possible so that carriers would have the maximum amount of time to work through them, OIC conducted a review of Coordinated Care's third filings, including assessment of its provider network. Despite all the work assisting Coordinated Care to create its network, OIC noted that there appeared to be several large gaps in the network as filed. OIC informed Coordinated Care of

the network gaps in the June 25, 2013 Disapproval Letter and, it was forced to, once again, provide Coordinated Care with a Disapproval Letter.

Coordinated Care's failure, or refusal, to correct the variability for the June 4 filing had cost it an entire month of time in which it could have been resolving the remaining issues. Thus, as a result of its three fatally flawed filings, Coordinated Care did not file a product that OIC could fully review until July 1, 2013. There were now only thirty days remaining before the deadline for all plans to be approved.

Fortunately, because the filing was now structured appropriately as an HMO product with no variability, OIC staff was able to review it more thoroughly than was possible before. OIC staff performed this thorough review as quickly as possible, and was finally able to provide Coordinated Care with a complete Objection Letter on July 17, 2013. An Objection Letter is a list of areas in which a filing is noncompliant, which must be corrected before it can be approved. The July 17th Objection Letter set forth 36 issues.

II. The Provider Network Filed By Coordinated Care Was Incomplete And Inadequate.

Arguably the largest and most difficult task in creating a commercial HMO is to create an adequate network of health care providers to deliver the HMO's benefits. Knowing this, OIC began in early 2012 working with carriers like Coordinated Care, who were seeking to enter the Exchange and were new to Washington's commercial health plan market. At the first of its 15 training sessions for carriers, OIC staff laid out the deadlines that these carriers would need to meet, and advised that if a carrier was not currently in the individual or small group market, it would need to build extra time into the filing review process. OIC advised such carriers to schedule a meeting with the OIC during the summer of 2012 to meet and discuss their business plans so that OIC could provide individualized assistance with creating networks. It advised that carriers did not have to create new provider networks, but if they chose to, that effort should already be underway.

OIC recommended that such carriers consider contracting with an existing provider network to save time and effort. OIC refers to this process as "renting a network." In August, 2012, Coordinated Care filed contracts with OIC to "rent" an existing provider network called First Choice Health Network ("First Choice"). Although First Choice is well known to OIC as a fully adequate network that would have satisfied the network adequacy requirement for Coordinated Care, the Company withdrew this contract and did not pursue this option. In October, 2012, Coordinated Care advised that it intended to offer each of its Medicaid providers the opportunity to amend their contracts so that those providers could also participate in the commercial network. The Company's expressed intention was to use its Medicaid provider network as the network for the Company's Exchange plan.

This is a viable option. However, it is extremely cumbersome and difficult because Medicaid contracts must reference a host of federal statutes due to the federal component of Medicaid. The addendum needed to amend a Medicaid provider contract for use as a commercial provider contract must withdraw all of those federal requirements and insert the requirements under State law. OIC was recommending that the carriers have their networks for their Exchange products built and approved by December, 2012, so that they could move on to the other pieces of building those products ahead of the July, 2013 deadline. Nonetheless, when the Company chose this path and filed its addendum in October, OIC worked extensively with it to resolve the issues involved. The Company obtained approval for that commercial amendment on March 13, 2013. Although it was behind schedule, Coordinated Care could now contract with its providers to build its commercial network.

Then, in April 2013, OIC received an inquiry from the Washington State Medical Association ("WSMA") regarding Coordinated Care's commercial provider contracts. WSMA reported that some of its member physicians had been offered contracts by Coordinated Care, but could not tell whether they had been approved by OIC. Upon OIC's examination, the forms turned out to be labeled with Coordinated Care's approved form number, but the Company had removed the approved language and inserted new language into the contracts. The new language violated Washington law, as did contracting using unapproved forms. OIC required Coordinated Care to pull back those noncompliant contracts and

reissue contracts to anyone with whom they had contracted using the noncompliant forms. This incident set the Company back another month in its efforts to build a commercial provider network.

The next step was review and approval of that network once it was built. The standards for network adequacy are set out in the Insurance Code. *See, e.g.*, RCW 48.43.515 and WAC 284-43-200. OIC ensures continued network adequacy by requiring carriers to submit a list of all providers contracted as part of their networks on the 10th of each month. This list of providers is called a "Form A." Under normal circumstances, OIC requires a carrier to have an approved network before it will allow the carrier to file its forms or rates, since the provider network is the critical piece and the most difficult to build. However, because of the time constraints involved with the July 31 deadline for Exchange filings, OIC had to allow new carriers to build networks while their rates and form were being analyzed. The agency had announced in early 2012 that it would conduct its review of new networks for use in Exchange plans using each network's June 10th, 2013 Form A.

OIC therefore analyzed Coordinated Care's June 10, 2013 Form A filing. The filings it submitted to OIC demonstrate that Coordinated Care did not have adequate arrangements in place to ensure that people covered under these products would have access to sufficient providers and facilities, within reasonable proximity, to obtain the services promised. On July 11, 2013, OIC sent Coordinated Care its findings, which were of grave concern. For example, there appeared to be entire categories of providers missing, such as Ear, Nose, and Throat specialists, pediatric hospitals, proctologists, and pulmonologists.

Staff recognized that there is one known issue with Form A filings that can cause "compression" of provider lists which results in falsely incomplete data. In an effort to ensure that this was not contributing to the troubling results, they instructed Coordinated Care in an alternative mechanism for filing to avoid this problem. Unfortunately, the Company did not properly report its providers in either format, rendering OIC staff unable to determine how many providers the network included. This is one of the reasons OIC has never been able to reconcile the number of contracted providers Coordinated Care has in its network with the number the Company claims to have.

This situation is a good example of two phenomena that contributed to Coordinated Care's ultimate failure to file a compliant Individual Exchange product. The first has previously been discussed; the Company lacked any experience with commercial products, Washington law, and the SERFF filing system. It was therefore at a disadvantage which all of OIC's assistance was simply unable to overcome. Second, on many occasions, though OIC provided specific, detailed instructions for resolving an issue, the Company failed to follow them.

The Company responded to OIC's findings on July 15, 2013. On July 15, 2013, OIC requested two additional pieces of network documentation called a Geographic Network Report ("GeoNetwork Report") and an Access Plan. The GeoNetwork Report includes a map which shows the location of contracted providers within the carrier's service area, and is used to demonstrate that plan enrollees will have an adequate number of providers within reasonable proximity to their homes. The Access Plan is a question and answer document that sets out the standards used in developing the network. Carriers may use any measure they choose to demonstrate this. Coordinated Care used mileage and showed that it had two contracted Primary Care Providers within 10 miles of 90% of its commercial enrollees, showing an adequate network of Primary Care Providers. However, the Access Report also showed that Coordinated Care's standard for an adequate network of chiropractors, acupuncturists, and midwives for urban areas was to have one such provider within 20 miles for 90% of enrollees. Coordinated Care's Form A showed the Company did not have any such providers. This, obviously, was inadequate.

Coordinated Care's Access Plan acknowledged insufficient numbers and types of in-network providers and requested permission for single case agreements and prior authorization requirements to manage enrollee access to non-contracted providers. Although WAC 284-43-200(3) allows the Commissioner to accept alternative arrangements in cases where a health carrier "has an absence of or an insufficient number or type of participating providers or facilities to cover a particular covered health care service," the Commissioner does not approve such requests for new product offerings, and certainly not to address a lack of a core category of provider. The Commissioner considers such exceptions only when a carrier faces a provider or facility termination in an established network. Contrary to Coordinated Care's assertion that "such occasional out of network arrangements are common to all provider networks,"

such arrangements are not used by carriers to fill a lack of core providers in their networks. They are used only when an extraordinarily uncommon specialty provider is needed to treat an enrollee's atypical condition. In other words, when a very rare, unforeseen medical situation occurs. Children requiring hospitalization and enrollees suffering burns are not rare or unforeseen medical situations.

OIC met with Coordinated Care the following day, July 16, 2013, to work on the provider network issue. Many of the issues proved to be simple errors in the way Coordinated Care had listed providers, rather than deficiencies in the network. However, the Company acknowledged that some of the gaps were real. Of those, some had been resolved. For example, although its filings showed that it did not currently have chiropractors, acupuncturists, or naturopaths in its network, the Company had just contracted with a provider network called HealthWays to provide those services. Coordinated Care filed a provider contract with OIC showing that had occurred.

This left two kinds of network adequacy problems which were not resolved by the July 31 deadline for Exchange plan approval: the lack of massage therapists, and the lack of two kinds of specialty hospital. The parties had several meetings attempting to resolve these issues, including both telephone conferences and in-person meetings. Amid these, the parties exchanged uncountable telephone calls and emails. In the case of the first issue, the Company failed to follow OIC instruction for resolution and therefore simply ran out of time to resolve it. In the case of the second issue, the Company refused (and continues to refuse) to include these required core providers in its network.

Massage Therapists:

During one of the July face to face meetings between the parties, Coordinated Care reported that it had no contracted massage therapists. Because the Company had already contracted with HealthWays for its chiropractor and naturopath providers, and the HealthWays network also includes massage therapists, Coordinated Care could fill its network gap by contracting with HealthWays to "rent" its fully-adequate massage therapy network. Coordinated Care chose to take this advice. The Company requested direction on how to make the filing to change the HealthWays contract to add massage

therapists. OIC provided explicit direction on two different ways the Company could accomplish this: by withdrawing the existing HealthWays provider contract filing and submitting a revised contract, or by filing a stand-alone amendment to the existing HealthWays contract. Rather than follow either path, on July 19th Coordinated Care filed a request within the SERFF system to amend the existing agreement it had already filed. As OIC had explained to Coordinated Care, this was not an option because it had been precluded by expiration of the time period allowed by law for making changes to filed provider contracts. Thus, due to the Company's failure to follow the correct procedure, it actually made the problem much worse. The Company's request to amend its contract filing necessitated that OIC disapprove and close the HealthWays provider agreement filing. The result was that the Company had no contracted chiropractors, acupuncturists, or massage therapists on July 31, the date Exchange plans had to be approved or closed. In fact, this situation remains the same today.

Specialty Hospitals:

Coordinated Care's network lacks two kinds of specialty hospital: A pediatric hospital and a Level 1 burn unit. When asked about the lack of pediatric specialty hospitals in its network, Coordinated Care noted that it is contracted with Providence Sacred Heart Children's Hospital in Spokane, Swedish Medical Center in Seattle, and Providence Regional Medical Center in Everett. (Although it was working to contract with Shriner's Hospital for Children in Spokane, that hospital was not in its network until late August, almost a month after the July 31 deadline for network approval.) This is not an adequate network for these providers. These hospitals are located only in Seattle, Everett, and Spokane, which still left enormous parts of the Company's service area without pediatric hospital providers. In other words, enrollees who paid for coverage believing that their children would have access to hospital care within a reasonable proximity – as the law guarantees and the Coordinated Care contract promises - would be misled.

Coordinated Care argued that these children could be treated at the general hospitals within its network, and that if they needed Level 1 trauma care, the Company would seek to enter into "spot contracts" to cover them. The Company made the same argument with regard to its lack of a Level 1

burn unit. (There is only one in the state – Harborview.) This is unacceptable on its face. Moreover, it poses potential harm to consumers, does not comply with Washington regulation, and is antithetical to the purpose of the ACA.

It is unreasonable for Coordinated Care to propose that, for any enrollee within the entire state who requires access to pediatric Level 1 trauma care or a Level 1 burn unit, the Company will – in the midst of that emergency – seek to enter into a contract with a provider to deliver that care. In addition, the Company would have to make a new contract for every single patient every single time. It is unreasonable to assume that these providers will be willing to spot contract with Coordinated Care. If the Company could have reached contracts with them, these providers would already be in its network.

There are thus two possible results of attempts to spot contract, both of which would harm the consumer: The provider could refuse to contract at all, which would be like not having coverage. Or, the parties could agree to a reimbursement amount, but not to the enrollee protections Coordinated Care is required by law to provide. The company argues that the patient will still be subject only to in-network cost sharing, which is correct. But this is meaningless because it does not protect the enrollee from the real danger, balance billing.

Coordinated Care's lack of these core providers is a violation of RCW 48.46.030 and WAC 284-43-200, which require Coordinated Care to have "adequate arrangements in place to ensure reasonable proximity to a *contracted* network of providers and facilities to perform services to covered persons under its contracted plans." While OIC agrees that general hospitals can provide most services, the relevant issue is that they cannot provide *all of the services promised in Coordinated Care's policy*. The laws cited above do not allow a *potentially* contracted network, they require a *contracted* network

The first reason for this is that striking a fair bargain with a provider is not possible in an emergency situation involving a single enrollee. The second reason is the harm to a consumer that could result from the unfair bargaining situation: balance billing.

For the protection of enrollees, Washington law requires that provider contracts include two types of "hold harmless" language. WAC 284-43-320. The first hold harmless protection is that the provider must agree not to seek payment from the insured for services performed under the contract. WAC 284-43-320(2)(a). For example, should the provider price its service at $100, but contract with the carrier to accept $75 to perform the service for its enrollees, the contracted provider may not seek the other $25 from the insured. This prohibited practice is called "balance billing." In fact, balance billing by a contracted provider is a Class C felony. RCW 48.80.030(5 and 6). The second hold harmless protection is that the provider must agree, in the event the carrier for any reason does not pay amounts it owes under the contract, not to seek payment from the insured. WAC 284-43-320(2)(a, c, and d).

Herein lies the hidden danger to enrollees from a carrier hoping to be able to "spot contract" in an emergency. The enrollee who suffers a catastrophic burn correctly believes he has purchased coverage for his care. Unbeknownst to him, this coverage is not established, but only potential. After his burn, he is airlifted to the Harborview Level 1 burn unit, and his treatment begins. Coordinated Care begins attempting to contract with the hospital for his care. Because it is in a poor bargaining position, the Company is able to settle on a price for the enrollee's care, but is unable to get Harborview to agree to the required hold harmless provisions. The enrollee is now subject to potentially enormous balance billing. He was not warned of this danger – in fact, Coordinated Care's policy tells him he can only be subject to his deductible and copayment amounts.

Coordinated Care's proposed policy definition of "eligible service" tells enrollees that for non-network providers (such as pediatric hospitals and the Level 1 burn unit), "the eligible service is the amount that has been negotiated with in-network providers for the same covered service. The member will be responsible for their same cost share amount they would pay to a network provider." This is incorrect. As explained above, the member is likely to be responsible for those costs, *in addition to* a substantial amount in balance billing by the provider. Coordinated Care alleges that this error was "completely addressed by Coordinated Care in its resubmission." It was not. The language quoted above is from that resubmission.

III. **The Health Benefit Plan Filed By Coordinated Care Contains Additional Violations Of State And Federal Law In Several Ways.**

OIC's July 31, 2013 Disapproval Letter sets out 15 bases that required OIC to disapprove Coordinated Care's Exchange product. Many of them are areas in which the proposed benefit structure violates Washington law. In analyzing this letter, it is important to understand that OIC has no authority to tell carriers what to put in their contracts. This is one of the differences between the purchase of Medicaid services by the Health Care Authority and regulation of commercial insurance products by OIC. Commercial carriers must do what it takes to file products that comply with the law. Thus, when OIC finds noncompliant provisions in a filed product, staff points out the noncompliant provision and cites the law it violates. It is the carrier's responsibility to read the law and correct the provision appropriately. OIC must regulate in this way, because a carrier can fix an issue in multiple different ways. Only the carrier may make decisions about its business processes and the features of its products. All OIC has authority to do is to ensure that those processes and features do not violate the law.

a. Issues With Rates

Of the numbered objections in OIC's July 31, 2013 Disapproval Letter, one through four are rate issues. Premium rates are reviewed to ensure that they are not "excessive, inadequate, or unfairly discriminatory." RCW 48.19.020. Rates must be reasonable in light of the benefits. Obviously, in order to ensure reasonable rates, OIC needs to know what those benefits are going to be. That is why the form filings describing the benefits were due on April 1, and the proposed rates were not due until May 1. However, the overwhelming issues with Coordinated Care's network and benefit structure precluded a thorough review of the Company's rate filing.

As described in Section 1 above, Coordinated Care did not file a reviewable product until July 1 and, as a result, OIC was not able to fully review the rates for the first time until then. It set forth the rate issues in OIC's July 17 Disapproval Letter. These issues were not addressed by Coordinated Care until July 25, 6 days prior to the deadline for approval. As a result, rate issues remain but would not have been

reparable until the network and forms issues were resolved. Thus, OIC will not focus on these rate objections as bases for disapproval. The fatal flaws in the network and the policy provisions alone would have required disapproval.

b. Issues With Dependent Coverage

OIC's sixth objection is that Coordinated Care's policy would require a family seeking to add an adopted child to its plan to meet conditions that a family seeking to add a biological child need not. Under RCW 48.01.180 and 48.46.490, once a family is providing full or partial support of a child for the purpose of adoption, the plan must allow that child to be added as a dependent. It thus violates those laws to require an additional letter of intent to adopt the child, or court order requiring coverage, in order to qualify.

Again, Coordinated Care alleges that this error was corrected. Again, it was not. The discriminatory requirements remain in the resubmission.

OIC's seventh objection is that Coordinated Care sought to prohibit a dependent child over age 26 to remain on the parents' policy only if that child had a "continuous total incapacity." This requirement violates RCW 48.46.320. That statute requires a carrier to allow dependent coverage for such a child so long as he is "(1) incapable of self-sustaining employment by reason of developmental disability or physical handicap; and (2) chiefly dependent upon the subscriber for support and maintenance." He need not have "continuous total incapacity" to qualify for coverage.

Coordinated Care did not correct this violation. The unlawful requirement remains in the resubmission.

c. Issues With Access To Brand Name Drugs

OIC's eighth basis for disapproval is that Coordinated Care's "Family Planning Services" provision violates both RCW 48.46.060(3)(a and d) and the ACA. A carrier may not place restrictions on access to

any FDA-approved contraceptive drugs or devices. The Company's proposed method of limiting provision of brand name drugs vs. generics is appropriate. However, when a company places such a limitation on access to these drugs, it must still accommodate any individual for whom generic drugs or brand name drugs would be medically inappropriate, as determined by the enrollee's provider. Thus, the plan structure must include a mechanism for waiving the otherwise applicable cost-sharing for the branded or non-preferred brand version in these situations. Coordinated Care's plan does not. Therefore, its enrollees who find themselves in this situation face the risk of being denied benefits to which they are legally entitled.

Despite its claim to the contrary, Coordinated Care did not correct this violation in its resubmission.

d. Issue With Durable Medical Equipment For Rehabilitative Services

The ninth basis for disapproval is that the Company's "Home Health Care Service Benefits" provision violates the ACA, as codified in WAC 284-43-878. A health benefit plan must cover "rehabilitative and habilitative services." "For purposes of determining a plan's actuarial value, an issuer must classify as rehabilitative services the medically necessary services that help a person keep, restore or improve skills and function for daily living that have been lost or impaired because a person was sick, hurt or disabled." WAC 284-43-878(7)(a). Rehabilitative and habilitative services includes "durable medical equipment and mobility enhancing equipment used to serve a medical purpose, including sales tax." WAC 284-43-878(7)(b)(v).

This law requires Coordinated Care to cover all medically necessary durable medical equipment. In contrast, Coordinated Care seeks to restrict its coverage to only the following: IV stand and IV tubing, infusion pump or cassette, portable commode, patient lift, bili-lights, suction machines and suction catheters.

Contrary to Coordinated Care's claim that it has corrected this illegal restriction, this list was taken from its resubmission.

e. Issue With Discriminatory Drug Deductible

The tenth basis for OIC's disapproval of Coordinated Care's Exchange plan is that the Company sought to place a $350 deductible on specialty drugs, which deductible does not exist for other drugs. This is illegally discriminatory against enrollees who have health conditions that require these drugs and is a violation of the community rating requirement. RCW 48.46.064, WAC 284-43-877(9)(c). Eliminating such discrimination and the resulting financial hardship for those needing expensive health care, of course, is one of the essential tenets of the ACA. In addition, all deductibles are required to be set forth as such – a policy may not include a hidden deductible such as this. Such a misleading provision authorizes OIC to disapprove the plan per RCW 48.46.060(3)(a).

Coordinated Care argues that it learned of this finding for the first time on July 31, thus denying the Company the opportunity to cure. This argument ignores Coordinated Care's responsibility to know and follow the law. OIC's role is to review the Company's product for compliance with Washington law. It is not to teach the law to carriers. Therefore, Coordinated Care cannot be heard to argue that it learned of the laws violated by this provision for the first time on July 31, 2013. Even if that is true, ignorance of the law is no defense for a violation of it. Finally, Coordinated Care did not include this provision in its filing until the submission of its schedule of benefits dated July 25, 2013. Given that, OIC could not have reviewed the filing and notified the Company of the violation any sooner.

f. Issue With Ambiguity Of Co Pay For Mail Order Drugs

The eleventh basis for disapproval of Coordinated Care's Exchange plan is that the amount the enrollee must pay for mail order drugs under the plan is not given. The latest Summary of Benefits, submitted on July 25, gives this amount as "3 times retail cost sharing." This is noncompliant in two ways. First, it is not possible to determine what the insurer means by this – what does the enrollee have to pay for his mail-order prescription drugs? Second, this amount must be either a dollar amount or a percentage of the total cost. Either way, the enrollee knows what he will have to pay. Moreover, because this is an enrollee cost for an Essential Health Benefit, it must be used as part of the calculation to determine

metal levels (which allow consumers to do that "apples to apples" comparison of plans for which the Exchange is designed). Without the appropriate information from Coordinated Care (i.e. a copayment amount or a coinsurance percentage), OIC is unable to calculate whether the Company's plans meet the metal levels the Company claims.

As discussed above, the Company's allegation that it became aware of this requirement, and its failure to meet it, on July 31 is simply not a basis upon which relief can -or should - be granted.

g. Issues With Premiums

OIC's twelfth basis for disapproval is that the "Premiums" section of Coordinated Care's proposed policy violates RCW 48.43.005(31). This section of the Company's policy states, "From time to time, we will change the rate table used for this contract form." It also says, "The contract, and age of members, type and level of benefits, and place of residence on the premium due date are some of the factors used in determining your premium rates." Rates for Exchange products may not be changed "from time to time," they may be changed only yearly. Moreover, they may be changed only for five specific reasons. RCW 48.46.064(a)(i-v). For that reason, an HMO contract may not provide a partial list of "some of the factors" that will be used to change rates; each reason must be specified so that OIC may ensure that only factors allowed by law are used.

Coordinated Care alleges that it has cured these problems in its resubmission, but the noncompliant language quoted above is from that resubmission.

h. Issues With Conflicting Information In The Filings And Technical Corrections

The thirteenth objection is that the Company's Pharmacy Benefit Template, Plans and Benefits template, and policy do not match. This is related to the problem outlined in OIC's Objection number 10. The Plans and Benefits template (or Prescription Drug Formulary template) dated July 1 indicates that these plans will utilize Coordinated Care's formulary called "WAF003." This formulary has four

tiers, and the filing indicates it utilizes a co pay dollar amount and no coinsurance. But when the Company filed its Schedule of Benefits on July 25, it included totally different co pay amounts, and included coinsurance. This is only one example, but when OIC reviewed the templates together (as it is required to do), staff found many entries that do not match.

This is unacceptable for two reasons. First, because this is information about what the enrollee will have to pay for medications ("cost share"), this information goes into the actuarial value calculator to determine whether the plan meets the metal levels that will allow "apples to apples" comparison on the Exchange. It must be correct in order to get the right result. It is also the information that goes to the federal Department of Health and Human Services for its review. More importantly, the Schedule of Benefits is the template that goes to the Exchange and is displayed to consumers. Therefore, the data provided by the Exchange would say one thing about cost share, but under the actual policy the consumer received, the cost for medication would be different.

Again, for all of the reasons set forth above, the Company's argument regarding lack of an opportunity to cure has no merit.

I Form, Rate, And Binder Do Not Match

OIC's fourteenth and fifteenth objections are simply technical corrections that would have been required to be corrected had all other issues been resolved. These are additional situations where the form, rate, and binder did not match, preventing OIC from reviewing the product because it could not know which was correct and which in error.

As with the objections above, the Company's argument regarding lack of an opportunity to cure has no merit.

The federal government has set August 31, 2013 as the deadline for the Exchange to submit the certified qualified health plans to the Department of Health and Human Services for federal review.

IV. The OIC Does Not Have The Authority To Grant The Relief Sought By Coordinated Care.

The relief requested by the Company as set forth in its Amended Demand for Hearing dated August 13, 2013, is "regulatory certification from the OIC to be presented to the Washington State Health Benefits Exchange as a qualified health plan for 2014." In other words, they seek to be approved based on the filings as of July 31, 2013, or they seek an extension of that deadline to cure the flaws identified by the OIC.

Based on the factual and legal deficiencies described above, the OIC respectfully submits that Coordinated Care's filings could not be approved by the OIC. Despite the extraordinary circumstances of the new Federal regulations, the OIC lacks authority to waive the requirements of the Insurance Code. Moreover, the Insurance Commissioner must abide by the deadline established by the Exchange for approval of health plans to be sold in the Exchange.

As to Coordinated Care's request to extend the deadline for an opportunity to cure the deficiencies in the filing, OIC respectfully submits that the Hearing Officer does not have the authority to grant this relief, because she stands in the shoes of the Insurance Commissioner and has only the authority granted to him by the Legislature. RCW 48.02.060(1) and (3)(c), 48.02.100. The OIC does not have the authority in regulation or Federal law to extend that deadline. Even if it could, to grant the relief sought by the Company would be to grant Coordinated Care an unjust advantage over all other carriers.

It is the Washington Health Benefits Exchange that has the authority to establish the deadline of July 31 for approved filings, and only the Exchange that can extend the deadline. The Exchange was created in 2011 by Washington House Bill 2319 as part of Washington's effort to implement the requirements of the federal Patient Protection and Affordable Care Act. Pursuant to RCW 43.71.020(1), the Exchange is a "public-private partnership separate and distinct from the state." Pursuant to RCW 43.71.030(1) and among other authorized activities, the Exchange – and only the Exchange - is authorized to "complete other duties necessary to begin open enrollment in qualified health plans through the exchange beginning October 1, 2013."

In order to meet the statutory open enrolment commencement date of October 1, 2013, the Exchange established the July 31, 2013 deadline by which issuers who wish to offer qualified individual exchange plans for 2014 had to have completed their OIC filing and approval process. The Insurance Commissioner does not have authority to extend it.

RCW 48.04.010(1)(b) provides, in pertinent part, that the Commissioner shall hold a hearing "upon written demand by any person aggrieved by any act, threatened act, or failure of the commissioner to act, if such failure is deemed an action under any provision of this code..." Under Washington's Administrative Procedure Act, RCW 34.05.010, "agency" and "agency action" are defined as follows:

> (2) "Agency" means any state board, commission, department, institution of higher education, or officer, authorized by law to make rules or to conduct adjudicative proceedings, except those in the legislative or judicial branches, the governor, or the attorney general except to the extent otherwise required by law and any local governmental entity that may request the appointment of an administrative law judge under chapter 42.41 RCW.
>
> (3) "Agency action" means licensing, the implementation or enforcement of a statute, the adoption or application of an agency rule or order, the imposition of sanctions, or the granting or withholding of benefits.

The Exchange, a public-private partnership distinct from the state, is not an "agency," and its actions or inactions, either establishing the July 31, 2013 deadline or declining to extend it, are not subject to review under the APA and would not be subject to adjudicative administrative review by the OIC even if Coordinated Care were to attempt to join the Exchange as a necessary party.

This jurisdictional defect is fatal to Coordinated Care Corporation's request for an extension of the Exchange's deadline. As stated in *Inland Foundry Company, Inc. v. Spokane County Air Pollution Control Authority*, 98 Wn. App. 121, 124, 989 P.2d 102 (1999):

> A tribunal's lack of subject matter jurisdiction may be raised by a party or the court at any time in a legal proceeding. RAP 2.5(a)(1); *Okanogan Wilderness League, Inc. v. Town of Twisp*, 133 Wn.2d 769, 788, 947 P.2d 732 (1997). Without subject matter jurisdiction, a court or administrative tribunal may do nothing other than enter an order of dismissal. *Crosby*, 137 Wn.2d at 301.
>
> ...
>
> An administrative review board has only the jurisdiction conferred by its authorizing statute. *Okanogan Wilderness*, 133 Wn.2d at 788-89.

Nor does the Insurance Commissioner have the authority to approve Coordinated Care's individual Exchange plan for sale in Washington. The plan violates both Washington and Federal law for all of the reasons set forth above. The Insurance Commissioner has only the authority granted by the Legislature. This grant does not include the authority to waive the requirements set forth in the Insurance Code.

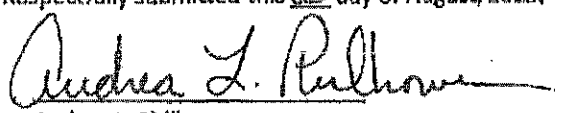
Finally, to approve this plan would work a grave injustice upon all of the carriers who submitted compliant plans that OIC was able to review and approve prior to the July 31 deadline. Coordinated Care has complained bitterly in the media that OIC did not afford it a "level playing field" in seeking approval of its Exchange products. Given the Company's public position that it was unfairly treated by OIC, its request that OIC now provide it an unfair advantage over all *other* carriers seems ironic. Be that as it may, OIC does acknowledge that Coordinated Care had more challenges than other carriers as a result of its inexperience in Washington's commercial health insurance market. This does not justify holding the Company to a lower standard than those others, even if OIC had that authority.

CONCLUSION

OIC believes the Company bears the burden of proof at hearing. OIC also believes the standard of review is abuse of discretion or error of law, and will show that it committed no legal error or abuse of discretion in disapproving Coordinated Care's individual Exchange products because they are riddled with errors, deficiencies, and violations of state and federal law. Despite extraordinary assistance and opportunities to file a product that complies with the law, the Company was unable to do so. OIC will demonstrate at hearing that the violations embodied in the proposed product would mislead and endanger consumers, the very hazard OIC review of such products is designed to prevent. OIC will, therefore, urge that OIC's disapproval of these filings be sustained.

In addition, OIC respectfully submits that the Hearing Officer does not have authority to grant the relief Coordinated Care seeks, and should therefore uphold OIC's disapproval of these filings on that ground.

Respectfully submitted this 23 day of August, 2013.



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FILED

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Hearings Unit, OIC
Patricia D Petersen
Chief Hearing Officer

BEFORE THE WASHINGTON STATE
OFFICE OF THE INSURANCE COMMISSIONER

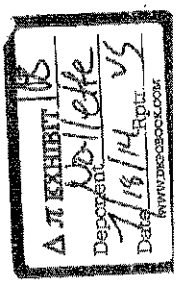
In the Matter of:

COORDINATED CARE CORPORATION,

A Health Maintenance Organization.

Docket No. 13-0232

MOTION OF INSURANCE COMMISSIONER MIKE KREIDLER FOR RECONSIDERATION OF FINDINGS OF FACT, CONCLUSIONS OF LAW, AND FINAL ORDER



I. INTRODUCTION

The Office of the Insurance Commissioner ("OIC") respectfully requests reconsideration of portions of the Findings of Fact, Conclusions of Law, and Final Order in the above-captioned matter, entered on September 3, 2013, ("Final Order"). OIC disapproved the rate, form, and binder filings filed by Coordinated Care Corporation ("Coordinated Care") on July 31, 2013.

First, the Order failed to properly resolve the conflict with a decision on the merits, and instead impermissibly directed settlement. While the Final Order properly concludes that some bases upon which the OIC disapproved Coordinated Care's filings were "valid", the Order failed to resolve the conflict by issuing a determination. Rather, the Order required the OIC to enter into a type of settlement negotiation with Coordinated Care, to result in refiling, approval, and entrance into the Exchange. Such a directive is improper, exceeds the scope of administrative judicial authority, and is unsupported in law.

Second, the Final Order's conclusions rested upon improper admission of evidence of settlement negotiations in unrelated litigation.

Third, the Final Order contains errors of law that effectively force the OIC to permit Coordinated Care to enter the Exchange with an insufficient network based on a contract methodology that is contrary to the laws applicable to health maintenance organizations ("HMOs").

Fourth, the Final Order contains Findings of Fact about communication between Coordinated Care and the OIC during the proceedings that are not supported by an objective evaluation of the record.

Despite the objections described in this motion, the parties have complied with the directives in the Final Order. The OIC recognized that there was no meaningful opportunity to bring this Motion prior to engaging in that work if Coordinated Care's plans were to be approved for the Exchange. Out of respect for the judicial process, the OIC has worked cooperatively with Coordinated Care to resolve those items that the Final Order identified as "valid" bases for disapproval, and the plans that were the subject of the hearing have now been approved for certification by the Washington Health Benefit Exchange.

II. ARGUMENT

A. The Final Order failed to resolve the matter with a decision on the merits, instead improperly directing settlement. In this, the Final Order exceeds administrative judicial authority, and is unsupported by law.

The Final Order does not resolve this matter with a decision on the merits. Instead, that order commands OIC to allow the Company to revise its filings, provide

"reasonable guidance and recommended language" to the Company to correct its deficiencies, and "give prompt and reasonable approval of the Company's filings provided the Company has addressed the reasons for disapproval..." Final Order, at 22. It goes on to state, "this proceeding shall remain open until the Company has made new/amended filings," and to require the parties to notify the Hearing Officer of the disposition of those filings.

The Final Order cites no authority in the APA, the Insurance Code, or otherwise, which allows the Hearing Officer to refuse to rule on a matter, instead holding that matter open until a compulsory settlement, the terms of which are dictated by the Hearing Officer, has been reached.

While the APA does strongly encourage informal settlements, it does not compel settlement. *See* RCW 34.05.431(1), WAC 10-08-130(1)(g), and WAC 284-02-070(2)(d)(iv) (allowing for prehearing conferences for settlement or simplification); RCW 34.05.437(1) and WAC 10-08-130(5) (requiring presiding hearing officers to allow parties the opportunity to make offers of settlement); RCW 34.05.060, WAC 10-08-130(5), and WAC 10-08-230 (encouraging informal settlements). However, the APA "does not require any party or other person to settle a matter." RCW 34.05.060. *See also* CJC 2.6(B) (prohibiting judges from acting "in a manner that coerces any party into settlement.")

Further, there is no authority in the Administrative Procedures Act (Title 34.05 RCW), the Model Rules of Procedure (WAC 10-08), the Insurance Code (Title 48 RCW), the rules promulgated under the Insurance Code (WAC 284), or the letter delegating authority to Hearing Officer to preside over hearings, that authorizes the Hearing Officer,

or any other Administrative Law Judge, to force the Insurance Commissioner, or his duly appointed Deputy Commissioners and staff to settle matters that they have determined should not be settled, particularly with a carrier whose filings have in fact been found deficient.

Nor is there any authority which allows a Hearing Officer to be privy to - let alone monitor – settlement negotiations. Certainly there is no authority for a judge to dictate the terms of settlement and warn that failure to settle on those terms "would be to invite a consideration that the OIC might have erred in disapproving the Company's filings on July 31." That disapproval was either correct or it was not. The Final Order appropriately sets this forth as the precise issue before the Hearing Officer. "Therefore, most clearly stated, in this proceeding, the Company bears the burden of proving, by a preponderance of the evidence, that on July 31, 2013 the OIC erred in disapproving Coordinated Care Corporation's June 25, 2013 Bronze, Silver and Gold Individual Plan Filings for 2014." Final Order, at 10, ¶2. There is no authority cited, nor could there be, for the proposition that an Administrative Law Judge may change a legal ruling as punishment for one of the parties' failure to cooperate with directives in an Order.

The Hearing Officer clearly has authority to find that the OIC properly disapproved Coordinated Care's July 31 filings. In large part, the Final Order does acknowledge that the OIC's reasons for rejecting Coordinated Care's July 31 filings were valid. There is no question that, had the Hearing Officer found the OIC's reasons for disapproval were all invalid, she has the authority to find that the OIC improperly rejected the filings as they existed on July 31, and order the OIC to accept those filings as they existed at the time. The Hearing Officer arguably even has authority to conduct a

new review using a legal definition or understanding that did not exist, or was not used when the original review was conducted. But the Final Order does not compel the OIC to approve or disapprove the filings as they existed on July 31, or to conduct a new review in light of a new analysis on a question of law. Instead, the Final Order acknowledges that the filings were largely deficient for the reasons asserted by the OIC, but nonetheless compels the OIC to enter into settlement negotiations with Coordinated Care to assist Coordinated Care in amending its filings in order to become acceptable to the OIC. Similarly, the Final Order cites no express or implied statutory authority allowing - let alone compelling - the OIC to draft portions of the very documents and filings that the OIC is compelled to regulate.

The Final Order essentially asserts that because the OIC chose to settle with certain companies, it was required to offer settlement to this company, and then compels the OIC into that settlement, even dictating the terms of that settlement (that OIC was to "promptly review and/or suggest amended language which would meet any remaining concerns that the current language is misleading or does not comply with applicable rules"). See, e.g., Final Order, at 19. However, the Final Order cites absolutely no authority for this command. None exists.

In ordering the OIC to settle its disputes concerning Coordinated Care's filings, the Final Order creates two dangerous precedents. First, it compels the OIC to not only provide specialized and directed legal advice to a specific private company, but to effectively draft portions of their contracts. Because the OIC regulates those same contracts, the Final Order has essentially created a conflict of interest for the OIC. The Final Order has created the very real potential for Coordinated Care to claim at a future

date, that the OIC cannot take enforcement action against Coordinated Care concerning those contractual provisions, because the OIC itself drafted them.

Further, in compelling settlement with one carrier because the OIC entered into settlement discussions with a wholly separate and unrelated carrier, the Final Order set the dangerous precedent that the OIC is now *compelled* to settle with any carrier who challenges the OIC's disapproval of their network, rate, form, or binder filings. The Final Order effectively broadcasts to every health carrier in the state that, by demanding a hearing on any disapproved filing, they can force the OIC to fix their contracts for them, monopolizing staff time, and unilaterally rearranging the distribution of OIC resources. This is particularly problematic because with the open enrollment deadlines of the ACA, beginning with this year and moving forward, there will always be a deadline for health plans to be approved. Usurping the OIC's resources by compelling settlement negotiations will have potentially devastating effects on the OIC's ability to approve plans. This issue will only get worse, as more carriers and plans enter the exchange, and more plans are subject to the federal deadlines that for this year only apply to plans offered in the Exchange.

What the Final Order attempts to do is compel the OIC's discretion. The Final Order notes, "For the OIC to use its discretion in allowing the Company to quickly make modifications now . . . is reasonable and permissible." Final Order at 22. However, the Hearing Officer does not have authority to compel the Commissioner's discretion, or that of his appointed Deputy Commissioners and staff. The Hearing Officer has authority to review decisions for compliance with the law, and to consider whether staff have *abused* their discretion. But no finding of an abuse of discretion was made in the record, nor was

evidence presented to meet the difficult showing that an agency has abused its discretion. In fact, the Final Order acknowledges that the OIC did the best it could under the unique and difficult circumstances imposed by the Affordable Care Act. Further, the Hearing Officer cannot rely on the OIC's decision not to enter into settlement negotiations as the basis for an abuse of discretion, because there is no legal requirement anywhere to compel the OIC to enter into settlement negotiations. While it may be permissible for the OIC to exercise its discretion in the manner suggested by the Hearing Officer, it is not permissible for a Hearing Officer to compel the exercise of that discretion in keeping with her own preferences.

OIC may be reading too much into the Final Order. The Final Order does state in several places that OIC is being compelled to re-write Coordinated Care's filings for it in light of the extraordinary situation presented by the fact that the Exchanges are an entirely new entity for which federal rules and guidelines were being promulgated even as the OIC was attempting to review plans for compliance with them. See, e.g., Final Order at 3, ¶3. The Final Order appropriately states that "it must be recognized that the specific situation involved in this particular review of the Company's filings is unique." Final Order, at 21.

It may be that such is the Hearing Officer's reasoning behind the directives in the Final Order, and is meant to apply only to Coordinated Care and only in this one, unique situation. If so, OIC urges the Hearing Officer to reconfigure the Final Order, making that abundantly clear. While the OIC stands behind its objections, the agency acknowledges that such a clarification would at least avoid the perils presented by reference to the Final Order as precedent.

B. The Final Order's conclusions rest upon improper admission of evidence of settlement negotiations in unrelated litigation.

OIC respectfully submits that the challenged directives in the Final Order rely on factual errors that 1) are supported solely by evidence of settlement negotiations introduced by the Hearing Officer, not by either party, and which should have been barred by ER 408, and 2) are not supported by the evidence in the record.

Over the OIC's objection, the Final Order relies on evidence that the OIC had entered into settlement negotiations with carriers in unrelated matters. Final Order at 8. Under Evidence Rule ("ER") 408, this information should never have been admitted into evidence, or considered by the Hearing Officer, in the Coordinated Care hearing.

ER 408 prohibits the admission of settlement negotiations for the purpose of proving liability. Although the Rules of Evidence are not strictly adhered to in administrative proceedings under the Administrative Procedures Act, Title 34.05 RCW ("APA"), they cannot be wholly ignored. RCW 34.05.452(2) still requires that a presiding hearing officer "shall refer to the Washington Rules of Evidence as guidelines for evidentiary rulings."

It is reversible error to admit evidence of settlement negotiations with third parties and in unrelated proceedings. *Grigsby v. City of Seattle*, 12 Wn.App. 453, 458, 529 P.2d 1167 (1975). In *Grigsby*, the plaintiff was a passenger in an automobile accident. *Id.* at 454. He settled with the driver of the car he was in, and subsequently sued the City of Seattle for negligent design, construction, and maintenance of the street. *Id.* The Court of Appeals found it was reversible error for the jury to be informed that the Plaintiff had settled with the driver. *Id.* at 458.

ER 408 does permit evidence of settlement negotiations for limited purposes, such as to prove bias, prejudice of a witness, negating claims of undue delay, or proving obstruction of justice. None of those claims were present in this case. In fact, the Hearing Officer found that the OIC witnesses were "credible, and presented no apparent biases." Final Order at 9-10. Nor was this presented by the OIC to negate claims of undue delay. No other exceptions to the prohibitions in ER 408 are present in the record.

Further, the APA provides that a "presiding officer shall not base a finding exclusively on such inadmissible evidence unless the presiding officer determines that doing so would not unduly abridge the parties' opportunities to confront witnesses and rebut evidence. The basis for this determination shall appear in the order." RCW 34.05.461. Here, the Final Order contains no such determination regarding the evidence presented by the Hearing Officer about settlement negotiations with other parties. On the contrary; the evidence of the OIC's settlement discussions with other carriers was not submitted by either party, but by the Hearing Officer herself. The Final Order cites no testimony or exhibit demonstrating the OIC's settlement negotiations with other carriers; Coordinated Care was apparently unaware of the OIC's settlement discussions with other carriers until the Hearing Officer introduced the subject. The OIC could only object; it had no opportunity to confront the Hearing Officer as a witness. She was not sworn in, and could not be questioned about basis for her conclusions that settlement talks with other carriers were relevant to this case, even though those carriers may have had entirely different licensure, filing deficiencies, or ability to promptly correct the problems in their filings.

The Hearing Officer's decision to not only consider, but inject, evidence of the OIC's settlement discussions in other proceedings as evidence that the OIC mishandled Coordinated Care's filings, also calls the Hearing Officer's impartiality into question. The Code of Judicial Conduct (CJC), though not binding on administrative law judges, is instructive to the extent it sets out the standards for judicial conduct in the State of Washington. Further, the APA provides that "Any individual serving or designated to serve alone or with others as presiding officer is subject to disqualification for bias, prejudice, interest, or any other cause provided in this chapter or for which a judge is disqualified." RCW 34.05.425(3). CJC 2.11(a) provides that "A judge shall disqualify himself or herself in any proceeding in which the judge's impartiality might reasonably be questioned", particularly in several specific circumstances. For example, when a judge has "personal knowledge of facts that are in dispute in the proceeding," or is "likely to be a material witness in the proceeding," that judge is obligated to recuse him or herself. CJC 2.11(1), (2)(d). By presenting the evidence of the OIC's settlement negotiations, the Hearing Officer essentially made herself a material witness concerning disputed factual allegations. In doing so, she has called into question her own partiality concerning this and every case involving the OIC's denial of a carrier's rate, form, and binder filings.

Impartiality by a judge and improper testimony by a witness both constitute grounds for granting a CR 59 motion for retrial or reconsideration on the basis of irregularity in the proceeding. *Edwards v. Le Duc*, 157 Wn.App. 455, 460, 238 P.3d 1187 (2010) (finding a CR 59 motion appropriate where the trial court demonstrated partiality repeatedly during the trial.); *Storey v. Storey*, 21 Wn.App. 370, 375, 585 P.2d

183 (1978) (finding a witness' testimony regarding inadmissible evidence a grounds for granting a CR 59 motion).

Because the Hearing Officer's presentation and admission of evidence of the OIC's settlement negotiations was improper under RCW 34.05.452(2), RCW 34.05.461, ER 408, and CJC 2.11, the Final Order should be reconsidered, omitting this improperly admitted information and the directives based upon it.

C. The Final Order contains errors of law that effectively force the OIC to permit Coordinated Care to enter the Exchange with an insufficient network, contrary to the laws applicable to health maintenance organizations.

In addition to improperly compelling settlement, the Final Order compels the acceptance of an inadequate network, in violation of the law.

Concerning the adequacy of Coordinated Care's network, the Final Order makes two legal errors. First, it erroneously conflates Coordinated Care's unchallenged Medicaid network as an "adequate network" for commercial products that, unlike Medicaid, must provide for 10 essential health benefits. Unfortunately, the Final Order does not provide its statutory or legal basis for the conclusion that a Medicaid network is automatically adequate for a commercial policy. Apparently, the Final Order misconstrues the provision of WAC 284-43-200, which provides that evidence of compliance with network standards for public purchasers "may be used to demonstrate sufficiency" to mean that, if a carrier has a Medicaid network for its Medicaid products, it has by operation of law demonstrated compliance with network standard for public purchaser concerning every service provided under the carrier's commercial contracts, regardless of whether public purchasers are required to include those services or providers. **This is particularly important for Medicaid carriers whose <u>Medicaid</u>**

plans do not have to offer all of the ten essential health benefits required under the ACA. Those ten essential health benefits are further defined by the state benchmark plan, and the rules promulgated by the OIC and the federal government. There is no discussion in the Final Order demonstrating that Coordinated Care's Medicaid plan, and Medicaid network, cover all of the essential health benefits required by law. Without such a determination, the existence of Coordinated Care's Medicaid network cannot demonstrate an adequate network for purposes of its commercial products.

In addition, the network Coordinated Care filed for its commercial products, and that was reviewed by the OIC, **was not Coordinated Care's Medicaid network**. The testimony and evidence at the hearing demonstrate that while the network filed by Coordinated Care was intended to include its Medicaid providers, it was a network built by Coordinated Care expressly for its Exchange plans. That is why the Company was contracting with HealthWays to include some of its providers in the new network, evidence of which was introduced and admitted without objection. It is because Coordinated Care's commercial network was not identical to its Medicaid network that the OIC was reviewing the network in the first place.

The second error the Final Order makes concerning Coordinated Care's network is to order the OIC to allow an HMO to satisfy its obligations to provide essential health benefits through non-networked providers. This is an express violation of RCW 48.46.030. The statutes governing HMOs require that to be licensed as an HMO, a carrier must provide:

> comprehensive health care services to enrolled participants on a group practice per capita prepayment basis or on a prepaid individual practice plan and provide[] such health services either directly or through

> arrangements with institutions, entities, and persons which its enrolled population might reasonably require as determined by the health maintenance organization in order to be maintained in good health . . .

RCW 48.46.030(1). Providing all covered services either directly, or through contracted providers, is a requirement for licensure as an HMO. Both Coordinated Care and the Final Order ignore this fundamental requirement for HMOs. Compelling the OIC to permit Coordinated Care to refuse to contract with the only facilities that can provide certain services that are covered by Coordinated Care's plans, forces the OIC to violate the law by licensing a carrier as an HMO that does not meet the requirements to be one.

OIC respectfully requests that the final order be revised in order to avoid forcing the OIC to take actions that are contrary to law in the future.

D. The Final Order contains Findings of Fact about communication between Coordinated Care and the OIC during the proceedings that are not supported by an objective evaluation of the record.

The Final Order contains the erroneous factual conclusion that OIC improperly refused to communicate with Coordinated Care following the July 31, 2013 denial. The Order moreover states that the OIC informed Coordinated Care that "the OIC was prohibited from communicating with the company because the Company had filed a Demand for Hearing," states that the OIC acted disingenuously in making this alleged statement, and scolded the OIC for failing to properly inform Coordinated Care of an alleged policy of refusing to communicate after a Demand for Hearing is filed. Final Order at 7-8.

There is no testimony in the record as to a policy of refusing to communicate. Dr. Fathi testified as to his understanding that OIC staff refused to communicate with

Coordinated Care because it was "against the law" to talk to a party during a hearings process. This reflects a layman's understanding of the situation, and the OIC refuted his claim. The OIC never stated it had a "policy" of refusing to communicate with carriers in litigation, or that the law prohibits the OIC from doing so. *See* Final Order at 8 and 12.

There is no such policy. Rather, as demonstrated by counsel for the OIC, both staff attorney Andrea Philhower and Deputy Commissioner AnnaLisa Gellermann, the OIC, facing impending expedited litigation, reasonably required the company to direct its discussions solely to the legal affairs staff that would be handling that litigation. This requirement is based upon Rule of Professional Conduct ("RPC") 4.2, a ubiquitous standard that is immediately put in place by any attorney representing any party in litigation.

Generally, RPC 4.2 also limits client discussions with parties known to be represented. *See* RPC 4.2, comment 7. This entirely reasonable direction provided Coordinated Care with a meaningful avenue to address its concerns, and utilized OIC's limited staff resources in the most efficient manner possible. Neither Coordinated Care, nor the Final Order cite to any authority that contravenes the Rules of Professional Conduct, or mandates that a party who is subject to litigation, participate in discussions concerning the subject of that litigation, without counsel present.

Because the findings that the OIC "refused" to communicate with Coordinated Care, and changed its reasoning for doing so, are not supported in the record, the Final Order should be reconsidered without these erroneous and unsupported findings, and the directives based upon them should be stricken.

III. CONCLUSION

Because the Final Order rests on significant but erroneous conclusions of fact and law, that stemmed from irregularities in the hearing process, the OIC respectfully requests that the Final Order be reconsidered.

DATED this 6th day of September, 2013.

Andrea L. Philhower
OIC Staff Attorney