STATE OF WASHINGTON
OFFICE OF THE INSURANCE COMMISSIONER

In re Seattle Children's Hospital's Appeal of OIC's Approvals of HBE Plan Filings	NO. 13-0293 INTERVENORS' JOINT OPPOSITION TO SEATTLE CHILDREN'S HOSPITAL'S MOTION FOR PARTIAL SUMMARY JUDGMENT

I. INTRODUCTION

SCH's Motion for Partial Summary Judgment ("SCH's Motion") should be denied in its entirety because SCH does not have standing to pursue this action.[1] SCH's Motion should also be denied because SCH has not provided any evidence that the OIC failed to consider or apply controlling federal or state law. To the contrary, the Declaration of Molly Nollette submitted by the OIC in support of its Motion to Dismiss provides definitive proof that the OIC did consider and apply such laws in correctly determining that the Intervenors' plans met the requirements under the Patient Protection and Affordable Care Act, 42 U.S.C. 18001, *et seq.* ("ACA"). *See* Declaration of Molly Nollette in Support of Motion to Dismiss Adjudicative Proceeding ("Nollette Decl."), ¶ 10 & Exs. H-J.

[1] As with the Intervenors' Joint Motion for Summary Judgment, the factual statements in this brief relating to the business of any Intervenor are made solely by that party; no Intervenor makes any representations as to the factual statements relating to any other Intervenor.

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Moreover, there is no legal requirement that the OIC give "consideration to the unique pediatric services available in this state only at SCH" or consider the "consequences [to SCH] of allowing these plans to exclude SCH from their exchange networks", as SCH implies. *See* SCH's Motion, 1. The Chief Presiding Officer has already correctly held that WAC 284-43-200(3) expressly allows carriers to utilize out-of-network providers for any purpose as long as the consumer is not put in a worse position. To the extent the Intervenors' members require SCH's "unique" emergency or approved services, it is undisputed that those members will be provided those services without any additional cost to them and that SCH will be paid for those services.

As noted in Intervenors' Joint Motion for Summary Judgment ("Intervenors' Motion"), which is incorporated herein by reference, there is abundant evidence that the Intervenors' networks are adequate under the applicable federal and state laws. SCH has not identified a single statute or regulation that requires the Intervenors to include SCH as a network provider. SCH's Motion makes clear that true motivation for its appeal is a desire to maximize its revenue from the Intervenors' HBE members. Fortunately, no law supports SCH's efforts to force the Intervenors to unnecessarily contract with SCH so that it can reap additional revenues at the expense of the Intervenors' members.

II. STATEMENT OF FACTS

The Intervenors provided a comprehensive recitation of the relevant facts in the Factual and Procedural Background section of Intervenors' Motion. To avoid repetition, the Intervenors hereby incorporate by reference that section as if fully set forth herein.

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III. ARGUMENT

A. SCH's Lacks Standing.

SCH's Motion ignores the critical threshold issue that SCH lacks standing to demand a hearing before the OIC. SCH's lack of standing renders its claims fatally flawed as a matter of law. The Intervenors argued this issue in detail on pages 11-16 of Intervenors' Motion, which is incorporated herein by reference. Nothing in SCH's Motion renders that analysis any less fatal to SCH's claims.

To have standing, SCH must prove that it has been aggrieved. RCW 48.04.010. As discussed in Intervenors' Motion, cases addressing standing to obtain judicial review under the Administrative Procedures Act ("APA") are extremely informative to this case. Under the APA, the question of whether a person has been "aggrieved" by – and thus has standing to challenge – an agency action invokes a two-pronged analysis. First, the person must meet the "injury-in-fact" requirement by demonstrating that "[t]he agency action has prejudiced or is likely to prejudice that person" and that "[a] judgment in favor of that person would substantially eliminate or redress the prejudice to that person caused or likely to be caused by the agency action." RCW 34.05.530; *see also Patterson v Segale*, 171 Wn. App. 251, 254, 289 P.3d 657 (2012). Second, the person must also meet the "zone of interest" test, demonstrating that "[t]hat person's asserted interests are among those that the agency was required to consider when it engaged in the agency action challenged." RCW 34.05.530. Failure to satisfy either of the requisite tests leaves the person without standing to challenge the agency action. *Id.* SCH does not meet ***either*** test.

1. **SCH Has Not Demonstrated That It Has Suffered or Will Suffer an Injury-in-Fact.**

SCH cannot and has not demonstrated that "[t]he agency action has prejudiced or is likely to prejudice" SCH and that "[a] judgment in favor of [SCH] would substantially eliminate or redress th[at] prejudice." RCW 34.05.530.

SCH's continued attempt to rely on alleged harm suffered by third parties (HBE enrollees and SCH's patients) cannot confer standing on SCH. *See Allan v. Univ. of Wash.*, 140 Wn.2d 323, 332-33, 997 P.2d 360 (2000); *West v. Thurston Cnty.*, 144 Wn. App. 573, 578, 183 P.3d 346 (2008). Only injury to SCH is relevant to the standing analysis. *Id.*; RCW 48.04.010 (providing that the ***aggrieved person*** may file a demand for a hearing).

In SCH's Motion itself, SCH does not allege that it has suffered or will suffer any harm.[2] SCH's accompanying Declaration of Eileen O'Connor makes only general and speculative arguments regarding its purported harm. *See* Declaration of Eileen O'Connor in Support of Seattle Children's Hospital's Motion for Partial Summary Judgment ("O'Connor Decl."), ¶¶ 9-12. In the O'Connor Declaration, SCH asserts that it "anticipates financial loss or injury . . . . due to inadequate payment rates and the administrative burden of the spot-contracting arrangements." *Id.* at ¶ 9. SCH's closer explanation of these "anticipated" alleged harms reveals precisely how theoretical they are. SCH speculates:

- "When a carrier limits the [Letter of Agreement or "LOA"] to specific services . . ., the result ***may*** be that the patient's unforeseen conditions require SCH to

[2] SCH alleges only that "[t]he OIC failed to give consideration to the undisputed facts as to how the use of 'spot-contracting' to obtain SCH's services as an out-of-network provider causes harm ***to SCH's patients***, and to SCH's ability to provide needed services" ***to patients***. SCH's Motion, p. 9 (emphasis added).

provide care outside the LOA that the carrier ***may or may not*** agree to reimburse after the fact;"

- Negotiations of LOAs with Exchange plan carriers ***is as yet untested***, and ***may*** result in additional complications not previously experienced regarding LOAs with other plans;
- After the fact negotiations with Exchange plan carriers expose SCH to financial risk, and ***likely*** will result in SCH and its clinicians providing uncompensated or inadequately compensated services . . .;
- In addition, ***to the extent*** that these carriers will only contract with SCH as an in-network provider for their Exchange plans at rates below generally accepted commercial rates, that reduction in compensation would constitute an additional injury to SCH.

Id. at ¶¶ 10-12 (emphases added).

Speculative assumptions, like those proffered by SCH, are insufficient to confer standing. *See Patterson*, 171 Wn. App. at 254; *KS Tacoma Holdings, LLC v Shorelines Hr. Bd.*, 166 Wn. App. 117, 129, 272 P 3d 876 (2012); *Allan*, 140 Wn.2d at 332. Furthermore, as explained in Intervenors' Motion, SCH's speculation that the Intervenors will not adequately compensate SCH for services provided to their HBE members is simply false. *See* Intervenors' Motion , p 13; *see also* Declaration of Rich Maturi filed in support of Intervenors' Motion (for Premera) ("Maturi Decl."), ¶ 3, Declaration of Beth Johnson filed in support of Interventors' Motion ("Johnson Decl."), ¶ 9; Declaration of Jay Fathi filed in support of Intervenors' Motion ("Fathi Decl."), ¶¶ 10-11 SCH cannot demonstrate that it is likely to suffer any certain and concrete injury that would justify a finding of standing to demand a hearing.

2. SCH Cannot Demonstrate That it is Within the Zone of Interest.

As discussed at length in Intervenors' Motion, SCH also lacks standing because it fails to meet the requisite "zone of interest" test. RCW 34.05.530(2). SCH has not and cannot show that its interests were among those the OIC was charged with considering because the purpose of the ACA and implementing state statutes is to protect ***consumers***, not providers. *See* Intervenors' Motion, pp. 13-16; 42 U.S.C. § 18031(c); WAC 284-43-200; RCW 48.43.001; RCW 48.46.010.

In the analogous case of *To-Ro Trade Shows v. Collins*, the Washington Supreme Court held that the host of RV trade shows lacked standing to challenge the statute requiring RV dealers to be licensed in order to participate in such shows, holding:

> To-Ro asserts that RCW 46.70.021 violates its First Amendment rights[3] by prohibiting it from allowing unlicensed dealers to display their vehicles at its trade shows. But plainly, To-Ro's interest in seeking declaratory relief lies outside the zone of interests regulated by RCW 46.70.021. ***The purpose of the dealer licensing statute is to protect the public*** from "frauds, impositions, and other abuses" by vehicle dealers. RCW 46.70.005. To-Ro is not a vehicle dealer, licensed or otherwise, nor is it acting in a representative capacity for any organization of consumers or vehicle dealers. . . . ***The interest To-Ro is seeking to protect is its own theoretical interest in increasing the number of exhibitors participating in its trade shows. To-Ro's potential financial interest as a show promoter clearly does not coincide with the statute's aim of protecting consumers from fraudulent or abusive conduct by vehicle dealers.***

To-Ro Trade Shows, 144 Wn.2d 403, 414-15, 27 P.3d 1149 (2001) (emphases added). Similarly, here, the ACA is intended to provide ***consumers*** with affordable healthcare. *See* 42 U.S.C. § 18031(c); WAC 284-43-200; RCW 48.43.001; RCW 48.46.010. SCH is neither a consumer nor an insurance carrier, and the interest it seeks to protect is its own theoretical interest in increasing the number of patients in networks that include SCH, for SCH's own profit and benefit. As in

[3] *To-Ro Trade Shows* is not an APA case, but it employs the same "zone of interest" analysis as do the APA cases.

To-Ro Trade Shows, SCH's potential financial interest as a provider of medical services clearly does not coincide with the ACA's aim of providing affordable healthcare to consumers. SCH is not within the intended zone of interests and therefore lacks standing to demand a hearing.

B. The OIC Correctly Determined that the Intervenors' Networks Were Adequate.

SCH alleges that the OIC failed to consider the federal and state requirements when evaluating the Intervenors' Exchange plans. *See* SCH's Motion, 5-6. This is incorrect. As noted in Intervenors' Motion, the Secretary may certify a qualified health plan that contains a mere ten percent of the essential community providers in the area, and generally must certify a plan that includes twenty percent of the area's essential community providers. *See* Intervenors' Motion, pp 20-21. The OIC reviewed and confirmed that each of the Intervenors' Exchange plans included at least 20 percent of the available essential community providers in their respective service areas. *See* Nollette Decl., ¶ 10 & Exs. H- J (attaching the essential community provider score results for the Intervenors used by the OIC to determine that all of the Intervenors exceeded federal essential community provider requirements); *see also* Johnson Decl., ¶¶ 16-17; Fathi Decl, ¶¶ 12-13.

Additionally, the undisputed evidence shows that the Intervenors' plans cover the essential health benefits as defined by RCW 48.43.715 and 42 U.S. C. § 18022(b)(1). *See* Johnson Decl., ¶¶ 16-17; Fathi Decl, ¶¶ 12-13. RCW 48 43.715 defines essential health benefits as:

> The services and items ***covered*** by a health benefit plan that are within the categories identified in Section 1302(b) of PPACA including, but not limited to, ambulatory patient services, emergency services...and pediatric services, including oral and vision care... [***Emphasis Added***].

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SCH does not deny that the Intervenors' plans all include pediatric services as a covered benefit. Rather, SCH attempts to characterize RCW 48.43.715 as a requirement that each plan include every provider of essential health benefits as a *network* provider. This interpretation is not supported by the plain language of the statute.[4] Each Intervenor network contains providers capable of providing specialty pediatric care and comprehensive pediatric services. This ensures access to the vast majority of pediatric benefits. *See* Johnson Decl., ¶ 14, Ex. A; Fathi Decl.,¶ 8; Maturi Decl.,¶ 2. Where an essential pediatric service is unavailable from a network provider, the Intervenors will ensure access through single case agreements or other arrangements with no harm to the consumer. *See* Johnson Decl. ¶ 9; Fathi Decl. ¶¶ 10, 11; Maturi Decl., ¶ 3.

Similarly, the state network adequacy laws do not require health plans to contract with every provider that provides a service not available elsewhere. Indeed, SCH did not identify a single statute or regulation that requires this. SCH claims that the OIC's network adequacy determination is deficient because it fails to take into account unique services that are only available at SCH.[5] Yet SCH simultaneously claims that it is the only provider in a multi-state

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[4] Furthermore, WAC 284-43-877(5) makes clear that although health plans are prohibited from limiting the scope of an essential health benefit category based on the type of provider delivering the service, "[t]his obligation does not require an issuer to contract with any willing provider."

[5] This claim is not supported by reliable or admissible evidence. The only evidence advanced to support SCH's position that it provides "unique services" is paragraphs 3-7 and Exhibit B to the O'Connor Declaration. While Ms. O'Connor states she is the Senior Director of Contracting and Payor Relations for SCH, she does not claim to have any personal knowledge pertaining to the services that are offered by SCH or by any other pediatric provider. *See* O'Connnor Decl., ¶ 1. As such, she has no foundation to reliably describe which of SCH's services are unique. Indeed, the exhibit itself identifies different individuals (other than Ms. O'Connor) as "sources" for the information. *See e g.*, O'Connor Decl., Ex. B, p. 1 ("Source: Judy Dougherty (VP Service lines, Surgical Specialties) / Robert Sawin (Surgeon in Chief, SCH)"); *see also id* at pp. 3, 7-12. None of these "sources" have provided declarations in support of SCH's motion. Moreover, Ms. O'Connor does not attempt to authenticate Exhibit B or provide any evidence that it is a business record. It is therefore also unauthenticated and

region to offer many of these unique services. O'Conner Decl., Ex. B (e.g. ["O]ne of two labs in the country (the other is Boston Children's) that does the lysosomal acid lipase test."; "Only spina bifida clinic in [Washington, Alaska, Montana, Idaho"]). By this logic, every health plan in Idaho, Alaska, Montana, and potentially the entire West coast must contract with SCH as a network provider. The law does not require this, recognizing that it is not feasible for a health plan to contract with a provider of *every* service that may be needed by a plan member.

The state network adequacy regulations also reflect this reality by including a provision for single case agreements within the network adequacy regulation. While WAC 284-43-200(1) provides that a "health carrier shall maintain each plan network in a manner that is sufficient in numbers and types of providers", WAC 284-43-200(3) expressly allows carriers to utilize out-of-network providers for any purpose as long as the consumer is not put in a worse position. This was confirmed by the Chief Presiding Officer in the Findings of Fact, Conclusions of Law, and Final Order entered in the *In re Coordinated Care Corporation* matter on September 3, 2013. *See* Fathi Decl., Ex. A (Final Order), 18 ("Virtually all carriers on occasion use 'single payor arrangements' in provision of network services. . . . The Company does include sufficient facilities to ensure that all health plan services - including pediatric and Level I Burn Services - are accessible to consumers without delay und within a reasonable area, and it [is] permitted

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inadmissible hearsay. *See* ER 801-802; ER 901 (requiring authentication by witness with knowledge).

RCW 34.05.452 states that "the presiding officer shall refer to the Washington Rules of Evidence as guidelines for evidentiary rulings." Under ER 602, "[a] witness may not testify to a matter unless evidence is introduced sufficient to support a finding that the witness has personal knowledge of the matter." *See also* CR 56(e) ("affidavits [filed in support of summary judgment motions] shall be made on personal knowledge, shall set forth such facts as would be admissible in evidence, and shall show affirmatively that the affiant is competent to testify to the matters stated therein."). As such, SCH has provided no admissible evidence to support its claim that its services are unique.

under WAC 284-43-200 to arrange for' single payor agreements' in the case that a pediatric specialty hospital is required or a Level I Burn Unit is required."). Coordinated Care's and BridgeSpan's use of single case agreements or other payment arrangements for SCH services complies with this regulation. *See* Johnson Decl., ¶¶ 6, 9; Fathi Decl., ¶¶ 10-11. Consequently, the OIC correctly determined that the Intervenors' networks complied with both state and federal network adequacy requirements.

C. SCH's Arguments Specific to Premera Also Fail.

1. Premera Has a Contract with SCH, and Premera's HBE Members Will Have In-Network Access to SCH for Services Not Available at Other Hospitals.

Premera has a contract with SCH, and Premera's members have access to unique services at SCH as an in-network benefit. Premera recognizes that in limited unique circumstances, SCH may provide pediatric services that are not available from other providers. Maturi Decl., ¶ 2. Premera will treat SCH as in-network with respect to unique services. *Id.*

In support of its argument seeking removal of Premera's plans from the HBE, SCH claims that Premera's members will only have access to SCH on an out-of-network basis. SCH's Motion, p. 8. As made clear in the Intervenors' Motion, this is simply wrong. For unique services, Premera's HBE members will have in-network access to SCH pursuant to the terms of Premera's previously-existing contract with SCH. Further, Premera will reimburse SCH for those unique services at the contract rates SCH has previously agreed to with Premera. *Id* As such, the OIC correctly determined that Premera's HBE members would have full access to the required essential health benefits, including the unique "pediatric services" available only at SCH.

To the extent SCH disagrees with Premera's interpretation of the parties' existing contract – a question that is not before the Court at this time – that would be a private contract dispute between Premera and SCH about how much Premera will pay SCH for these unique services, an issue that does not implicate the ACA. Any disagreement about the existing contract does not affect Premera HBE members' access to unique services from SCH. As discussed in more detail below, SCH would need to seek adjudication of any breach of contract claim against Premera in a different forum. Such a dispute is subject to dispute resolution procedures in the parties' contract. *See* Nollette Decl., Ex. A (Premera-SCH contract).

One additional reason any contract dispute between Premera and SCH is not relevant to the issues currently before this tribunal is that were SCH to prevail on any such claim, Premera would "spot contract" with SCH in a manner similar to Coordinated Care and BridgeSpan.

2. SCH and Premera Must Resolve any Contract Dispute Between them through Contractual Dispute Resolution Procedures in their Contract.

As noted above, if SCH seeks to argue that its existing contract with Premera does not allow Premera to treat unique services received by its HBE members at SCH as in network claims, this is a dispute about the rate Premera will pay SCH for those unique services However, SCH does not contend that the Insurance Commissioner would have jurisdiction over what is simply a contract dispute between two commercial entities.

SCH alleges the OIC's jurisdiction to adjudicate this dispute arises from RCW 48.04.010, which provides that, "[t]he [insurance] commissioner may hold a hearing for any purpose within the scope of this code as he or she may deem necessary." The OIC's ability to conduct hearings is limited to issues "within the scope of the [insurance] code." *Id.* RCW 48.04.010 does not provide jurisdiction over hearings for all insurance-related issues. Here there is no jurisdictional

basis (or reason) for the OIC to adjudicate any contract dispute between SCH and Premera. And SCH should not be able to upset the OIC's and HHS's approval of Premera's network as adequate by merely alleging that Premera's plan to provide its HBE members access to SCH's unique services by alleging that such an action would be a breach of the parties' existing contract.

In *Shin v. Esurance Ins Co.*, C8-5626 RBL, 2009 WL 688586 (W.D. Wash. Mar. 13, 2009), the court held that a plaintiff did not have administrative remedies where plaintiff's claim involved an issue that did "not fall within the purview of the OIC." Any contract dispute between Premera and SCH would not fall within the purview of the OIC. The *Shin* court declined to extend RCW 48.04.010, explaining that "it is not at all clear that the conduct [plaintiff] alleges is explicitly prohibited by the Insurance Code." *Id.* The court limited jurisdiction to issues that "Washington statutes extensively regulate, and specifically provide remedies" such as premium rates (which do fall within the purview of the OIC). *Id.*

The parties' contract contains dispute resolution procedures that would govern any contract dispute. This Court should decline to adjudicate any such dispute between Premera and SCH.

3. The OIC Has Correctly Determined that Premera Need Not Include SCH in the HBE Network for Non-Unique Services.

WAC 284-43-200 provides that the OIC considers, among other things, "the willingness of providers or facilities in the service area to contract with the carrier under reasonable terms and conditions." It is undisputed that when Premera's HBE members receive unique services at SCH, those claims will be treated as in network, and SCH will be reimbursed at its existing agreed upon contractual rate with Premera. SCH appears to be arguing that it is unwilling to

accept the previously-negotiated rates between Premera and SCH when seeing Premera's HBE members for unique services.

While SCH does not say so explicitly, the true basis for its complaints related to Premera appears to be that Premera is limiting its HBE members' in-network access to SCH to unique services, and that non-unique services be treated as out of network. However, nothing in the ACA or HHS's regulations requires Premera to treat SCH as in-network with respect to all medical services it can possibly provide. Premera may limit its HBE members' access to SCH services on an in-network basis to unique services.

IV. CONCLUSION

For the foregoing reasons, the Intervenors respectfully request that the Chief Presiding Officer deny SCH's Motion and grant their Joint Motion for Summary Judgment.

DATED this 24th day of January, 2014.

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CERTIFICATE OF SERVICE

I, Cindy Castro, hereby certify that I am employed at the law firm of Stoel Rives, LLP, over the age of 18 years and not a party to this action. On January 29, 2014, I caused to be delivered in the manner indicated a copy of the foregoing document on the following parties:

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