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In the Matter of	)	NO. 13-0293
	)	
SEATTLE CHILDREN'S HOSPITAL,	)	OIC STAFF'S MOITON TO DISMISS DEMAND FOR HEARING AND TO TERMINATE ADJUDICATIVE PROCEEDING
	)	
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	)	

RELIEF REQUESTED

OIC staff requests entry of an order dismissing the Hearing Demand of Seattle Children's Hospital as a matter of law.

SUMMARY

The OIC approvals the Hospital challenges involve plans that have been certified as qualified benefit plans under the Affordable Care Act by the Washington Health Benefit Exchange and by the United States Department of Human and Health Services. In some Washington counties, no other Washington Health Benefit Exchange plans are available. Thousands of Washington residents have enrolled in these plans and are now relying on them for health coverage in 2014. One of the carriers, Premera, has a contract with the Hospital. However, the Hospital disputes application of the contract to Premera's Washington Health Benefit Exchange plans. Another of the carriers, Coordinated Care, has already had a full evidentiary hearing in which the Chief Presiding Officer explicitly ruled that carriers are not required to include pediatric hospitals in their networks.

Even if the Hospital is deemed to be an intended beneficiary of the state and federal network adequacy laws and an entity whose interest was required to be considered by the OIC in approving these plans, the Hospital's Demand for Hearing misconstrues the governing statutes and raises non justiciable issues upon which no effective relief can be granted. The OIC staff therefore respectfully submits the Demand for Hearing is subject to dismissal as a matter of law.

FACTS

The Hospital's Demand for Hearing in this case challenges the OIC's 2013 approvals of the Washington Health Benefit Exchange plans of four health carriers, Coordinated Care Corporation, Molina Healthcare of Washington, Inc., Premera Blue Cross, and BridgeSpan Health Company, based upon the theory that the carriers' failure to contract with the Hospital renders their provider networks legally inadequate under state and federal law. After the Demand was filed, Molina contracted with the Hospital, mooting the Hospital's contentions as to the Molina HBE plan.

Premera has a contract with the Hospital. (Nollette Declaration, Ex. "A") However, Premera and the Hospital dispute whether the contract applies to Premera's HBE plan enrollees. (Nollette Dec., Exs. "B" and "C.") The contract has a dispute resolution clause calling for the superior court to decide non billing disputes that cannot be resolved through mediation. (Nollette Dec., Ex "A," Section 7.02.)

BridgeSpan and Coordinated have no existing contract with the Hospital and will cover any unique services available only at Seattle Children's Hospital by spot contracting or paying billed charges. In OIC matter Number 13-0232, Coordinated Care litigated the question of whether its HBE plan network is adequate. The Findings of Fact,

Conclusions of Law and Final Order entered in the matter on September 3, 2013 reject the theory now advanced by the Hospital, concluding that "carriers are not required to include Level 1 Burn Units or pediatric hospitals in their networks." (Nollette Dec., Ex. "D," Conclusion of Law No. 12 (b), p.17.) Although the Hospital attempted to intervene in the earlier Coordinated Care proceeding, it waited until the Findings of Fact, Conclusions of Law and Final Order had been entered before making its motion, and its motion was denied. (Letter denying motion to intervene, Nollette Dec., Ex. "E.")

All three of these HBE plans have now been certified as qualified health plans by the Washington Health Benefit Exchange and by the United States Department of Human and Health Services. In several Washington counties, the Premera plan is the only HBE plan available and thousands of Washington residents have enrolled in these plans and are relying on them for their health coverage in 2014. (Nollette Dec. p. 3, Declaration of Christopher Blanton, p. 2., Declaration of Jay Fathi, p. 5, par. 18.)

OIC staff believes the Hospital's attempt to decertify these HBE plans and derail the Washington Health Benefit Exchange's 2014 coverage in order to force carriers to contract with the Hospital on the Hospital's terms constitutes a misuse of the OIC's hearing process that raises no justiciable issue. Hence this motion.

ARGUMENT AND AUTHORITY

A. SUMMARY JUDGMENT CRITERIA

Pursuant to CR 56 (b) "A party against whom a claim ... is asserted ... may move with or without supporting affidavits for a summary judgment in his favor as to all or any part thereof." CR 56(c) further provides in pertinent part as follows:

> The judgment sought shall be rendered forthwith if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law.

B. JUSTICIABILITY

An administrative review board has only the jurisdiction expressly conferred by its authorizing statute or necessarily implied therein. *Seattle v. Dept. of Ecology*, 37 Wn. App. 819, 823, 683 P.2d 244 (1984); *Anderson, Leech & Morse, Inc. v. State Liquor Control Bd.*, 89 Wn.2d 688, 694, 575 P.2d 221 (1978).

The authorizing statute here is RCW 48.04.010(1)(b) which 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…" (Emphasis supplied.) The legislature has defined agency "action" as follows:

> "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. RCW 34.05.010(3)

The "actions" the Hospital challenges here are the OIC's approvals of three health plans. These approvals do not involve licensing, statutory enforcement, sanctions, benefits, or rule or order adoption, leaving only the "implementation" of a statute as a jurisdictional basis for conducting an adjudicatory administrative proceeding. But here, OIC's " implementation" of network adequacy statutes presents no justiciable controversy in so far as Seattle Children's Hospital is concerned.

The elements of justiciability are set forth in *Washington Education Association v. Public Disclosure Commission*, 150 Wn.2d 612, 613, 80 P.2d 608 (2003):

> We steadfastly adhere to "'the virtually universal rule'" that there must be a justiciable controversy before the jurisdiction of a court may be invoked. *To-Ro Trade Shows v. Collins*, 144 Wn.2d 403, 411, 27 P.3d 1149 (2001) (quoting *Diversified Indus. Dev. Corp. v. Ripley*, 82 Wn.2d 811, 814-15, 514 P.2d 137 (1973)), *cert. denied,* 535 U.S. 931, 152 L. Ed. 2d 215, 122 S. Ct. 1304 (2002). For a justiciable controversy to exist there must be: "(1) . . . an actual, present and existing dispute, or the mature seeds of one, as distinguished from a possible, dormant, hypothetical, speculative, or moot disagreement, (2) between parties having genuine and opposing interests, (3) which involves interests that must be direct and substantial, rather than potential, theoretical, abstract or academic, and (4) a judicial determination of which will be final and conclusive." *To-Ro Trade Shows*, 144 Wn.2d at 411 (quoting *Diversified*, 82 Wn.2d at 815); *see also Wash. Beauty Coll., Inc. v. Huse*, 195 Wash. 160, 164-65, 80 P.2d 403 (1938). All four of the justiciability factors "must coalesce" to ensure that the court does not "step[] into the prohibited area of advisory opinions." *Diversified*, 82 Wn.2d at 815.

Even if Seattle Children's Hospital is deemed to have standing to litigate the application of network adequacy laws to the enrollees of these plans, there is no relief the Chief Hearing Officer can grant the Hospital that will be final and conclusive and within the OIC's adjudicatory jurisdiction.

First, the Washington Health Benefit Exchange and the United States Department of Human and Health Services have certified these three plans as qualified health benefit plans under the federal Affordable Care Act. These certifications carry with them the final determination in the approval process that the carriers' networks are adequate.

42 USCS § 18031(c)(1)(B) requires the Secretary of DHHS to "establish criteria for certification of health plans as qualified health plans." These criteria include the plan offering "a sufficient choice of providers…" 42 USC § 18031(c)(1)(B).

Even if the Hospital could demonstrate that any of the three plans that are the subject of its Demand for Hearing fail to meet these standards, which it cannot, the decision whether to decertify a plan offered through a state exchange is a decision that is

ultimately for the Exchange, not an OIC administrative law judge, to make. 45 CFR § 155.1080, headed "Decertification of QHPs," provides as follows:

> (a) Definition. The following definition applies to this section:
>
> Decertification means the termination by the Exchange of the certification status and offering of a QHP.
>
> (b) Decertification process. Except with respect to multi-State plans and CO-OP QHPs, the Exchange must establish a process for the decertification of QHPs, which, at a minimum, meets the requirements in this section.
>
> (c) Decertification by the Exchange. The Exchange may at any time decertify a health plan if the Exchange determines that the QHP issuer is no longer in compliance with the general certification criteria as outlined in § 155.1000(c).
>
> (d) Appeal of decertification. The Exchange must establish a process for the appeal of a decertification of a QHP.
>
> (e) Notice of decertification. Upon decertification of a QHP, the Exchange must provide notice of decertification to all affected parties, including:
>
> (1) The QHP issuer;
>
> (2) Exchange enrollees in the QHP who must receive information about a special enrollment period, as described in § 155.420;
>
> (3) HHS; and
>
> (4) The State department of insurance.

In short, this is not the tribunal and an RCW 48.04.010 hearing is not the process for decertifying a qualified health plan.

Second, this tribunal has no jurisdiction to force any health carrier to contract with any particular provider. Depriving thousands of Washington residents of the coverage they selected surely provides no "relief" to Seattle Children's Hospital. This tribunal

simply cannot unwind the events that have taken place since the plans were approved. If the OIC now reverses its approval of these plans as the Hospital requests, the Hospital will be in exactly the same legal position it is in today. It will still have no contract with BridgeSpan or Coordinated Care. Its contract with Premera will still be in dispute, and no individual will have a more sufficient or adequate choice of providers than he or she does today.

Third, this tribunal has no jurisdiction to try the merits of Premera's contract dispute with the Hospital. The parties to the contract have committed such disputes to mediation and superior court. No adjudication this tribunal can render will finally and conclusively resolve the meaning of the Hospital's contract with Premera. The OIC staff respectfully submits that jurisdiction to adjudicate such contract disputes is neither ancillary to, nor necessarily implied in, the Commissioner's limited jurisdiction under RCW 48.04.010 to provide a hearing to persons aggrieved by agency action.

"A tribunal lacks subject matter jurisdiction when it attempts to decide a type of controversy over which it has no authority to adjudicate." *Marley v. Dep't of Labor & Indus.*, 125 Wn.2d 533, 539, 886 P.2d 189 (1994). 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.

Second guessing the OIC's approval of these HBE plans at this late date serves no practical or legal purpose. The presiding officer can provide no final, conclusive or

effective remedy for the Hospital's alleged injury. Because the Hospital's Demand for Hearing invites this tribunal to adjudicate a clearly non justiciable case, the Demand for Hearing should be dismissed as a matter of law.

C. NETWORK ADEQUACY STANDARDS

The Hospital's Demand for Hearing is devoid of substantive legal merit in any event and is subject to dismissal as a matter of law on this ground as well.

As noted, the ACA requires that qualified health plans offer "a **sufficient** choice of providers..." 42 USC § 18031(c)(1)(B) (Emphasis supplied.) RCW 48.43.515(1) similarly provides that "each enrollee in a health plan must have **adequate** choice among health care providers." (Emphasis supplied.)

Contrary to the Hospital's theory, a "sufficient" or "adequate" choice of providers does not require a carrier to contract with every "essential community provider" nor does it require that every unique medical service that might conceivably be covered be available from a network provider. 42 USCS § 18031(c)(1)(C) requires the Secretary's certification criteria for qualified health plans to:

> (C) include within health insurance plan networks those essential community providers, where available, that serve predominately low-income, medically-underserved individuals, such as health care providers defined in section 340B(a)(4) of the Public Health Service Act [42 USCS § 256b(a)(4)] and providers described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act [42 USCS § 1396r-8(c)(1)(D)(i)(IV)] as set forth by section 221 of Public Law 111-8, except that nothing in this subparagraph shall be **construed to require any health plan to provide coverage for any specific medical procedure;** (Emphasis supplied.)

Even though the Hospital may serve predominately low-income, medically-underserved individuals and therefore qualify as an "essential community provider," neither it, nor any specialty pediatric medical procedures it may be uniquely qualified to

perform, is indispensable to an adequate network. Pursuant to 45 CFR § 156.230, a QHP network must include "essential community providers in accordance with § 156.235." 45 CFR § 156.235(a)(1) and (3) in turn provide that "a QHP issuer must have a sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the QHP's service area, in accordance with the Exchange's network adequacy standards" and that "nothing in this requirement shall be construed to require a QHP to provide coverage for any specific medical procedure provided by the essential community standard."

The Center for Medicare and Medicaid Services has made it clear that a plan that includes twenty percent of the essential community providers in the carrier's service area will qualify as a QHP and that an issuer may qualify with as few as ten percent. The CMS advisory letter to issuers dated April 5, 2013, page 7, (Nollette Dec., Exh. "F") provides in part as follows:

> □ **Safe Harbor Standard**: An application for QHP certification that demonstrates compliance with the standards outlined in this paragraph will be determined to meet the regulatory standard established by 45 C.F.R. § 156.235(a) without further documentation. First, the application demonstrates that at least 20 percent of available ECPs in the plan's service area participate in the issuer's provider network(s). In addition to achieving 20 percent participation of available ECPs, the issuer offers contracts prior to the coverage year to:
> o All available Indian providers in the service area, using the model QHP Addendum for Indian providers developed by CMS; and
> o At least one ECP in each ECP category (see Table 2.1) in each county in the service area, where an ECP in that category is available.
> CMS may verify the offering of contracts after certification.
> □ **Minimum Expectation**: An issuer application that demonstrates that at least 10 percent of available ECPs in the plan's service area participate in the issuer's provider network(s) for that plan will be determined to meet the regulatory standard, provided that the issuer includes as part of its application a satisfactory narrative justification describing how the issuer's provider network(s), as

currently designed and after taking into account new 2014 enrollment, provides an adequate level of service for low-income and medically underserved enrollees.

CMS filing instructions for an essential community provider's qualified health plan application recognizes six categories of essential community providers: "Federally Qualified Health Center (FQHC), Hospital, Ryan White HIV Provider, Indian Provider, Family Planning Provider, and Other ECP." (Nollette Dec. Exh., page 7-1, note 1.) Pediatric specialty hospitals such as Seattle Children's Hospital and even children's hospitals in general are not a category of ECP that must be included. The CMS filing instructions further provide on page 7-10:

> If the applicant's service area meets the 20 percent threshold, but the applicant does not agree to offer a contract to at least one ECP in each available ECP category in each county in the service area, submit a supplemental response describing how the applicant's provider networks provide access to a broad range of ECP types, including providers specializing in HIV/AODS treatment and co-morbid behavioral health issues as well as providers of women's health and reproductive health services.

As the foregoing statutes and the CMS instructions make clear, even though Seattle Children's Hospital may be an "essential community provider," it is not indispensable and neither the hospital nor any specific medical procedure it offers need be included in a carrier's contracted network in order for the plan to have an adequate network and constitute a qualified health plan under federal law.

The same is true under state law. As noted, the state statutory standard for network adequacy is set out in RCW 48.43.515(1) which requires health plan issuers to provide enrollees an "adequate choice among health care providers." This statute clearly contemplates that every specialty service that may be covered by a plan may not be available from a participating specialty provider. RCW 48.43.515(4) provides:

(4) Each carrier must provide for appropriate and timely referral of enrollees to a choice of specialists within the plan if specialty care is warranted. If the type of medical specialist needed for a specific condition is not represented on the specialty panel, enrollees must have access to nonparticipating specialty health care providers.

The fact that a network need not include every provider who is legally qualified to provide a covered health service is confirmed by the following language in WAC 284-43-205(4):

> Health carriers offering plans with restricted networks may select the individual providers in any category of provider with whom they will contract or whom they will reimburse. A health carrier is not required by RCW 48.43.045 or this section to accede to a request by any individual provider for inclusion in any network for any health plan.

WAC 284-43-200(3) underscores the fact that carriers may make arrangements for providing covered services other than by participating provider contracts:

> In any case where the health carrier has an absence of or an insufficient number or type of participating providers or facilities to provide a particular covered health care service, the carrier shall ensure through referral by the primary care provider or otherwise that the covered person obtains the covered service from a provider or facility within reasonable proximity of the covered person at no greater cost to the covered person than if the service were obtained from network providers and facilities, or shall make other arrangements acceptable to the commissioner.

The object of Washington's network adequacy statutes and rules is to provide enrollees with choice. It is not to give providers monopoly bargaining leverage. These statutes and rules, like their federal counterparts, give no legal right to any provider, no matter how specialized or qualified, to demand inclusion in any carrier's network of contracted providers.

CONCLUSION

Seattle Children's Hospital in this case seeks to use federal and state network adequacy laws and the OIC hearing process to coerce carriers into entering all or nothing

tying contracts with reimbursement rates for routine services dictated by the Hospital at levels that far exceed competitive rates. Federal and state network adequacy laws were never intended for such use and cannot be stretched so far. The Chief Hearing Officer's prior ruling that carriers are not required to include pediatric hospitals in their networks was legally correct. Because the Hospital's claims are devoid of substantive legal merit and because they raise non justiciable issues as to which no effective and final relief can be granted, the OIC staff respectfully submits that summary judgment is appropriate and that the Hospital's Demand for Hearing should be dismissed as a matter of law.

DATED this 14th day of January, 2014.

Charles D. Brown
Staff Attorney
Legal Affairs Division
Office of Insurance Commissioner

CERTIFICATE OF MAILING

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

On the date given below I caused to be served the foregoing OIC STAFF'S MOTION TO DISMISS DEMAND FOR HEARING AND TO TERMINATE ADJUDICATEVE PROCEEDING on the following individuals via Hand Delivery, US Mail and e-mail at the below indicated addresses:

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SIGNED this 15th day of January, 2014, at Tumwater, Washington.

Christine M. Tribe
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