BEFORE THE STATE OF WASHINGTON
OFFICE OF THE INSURANCE COMMISSIONER

In the Matter of: **SEATTLE CHILDREN'S HOSPITAL,** A Washington Not-For-Profit Corporation.	**Docket No. 13-0293** **DECLARATION OF JAY FATHI, MD IN SUPPORT OF INTERVENORS' JOINT MOTION FOR SUMMARY JUDGMENT**

I, JAY FATHI, declare as follows:

1. I have been a board certified family medicine physician in Washington State since 1996 and am currently the President and CEO of Coordinated Care Corporation ("Coordinated Care"). I make this declaration in support of Coordinated Care's Petition for Intervention. I am over the age of 18, competent to testify, and make the following statements based on my personal knowledge.

2. In 2012, Washington Insurance Commissioner Mike Kreidler began the review process for participation in the Washington Health Benefits Exchange ("HBE"). Coordinated Care submitted proposed rates, proposed contract forms, actuarial information, and other information required by the Patient Protection and Affordable Care Act ("ACA") and the Washington Office of Insurance Commissioner ("OIC") for inclusion in the 2014 HBE. In particular, Coordinated Care submitted multiple documents to the OIC establishing its network

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adequacy by both specialty and primary care provider-covered person ratios and by geographic accessibility, including its Form A filings and its Network Access Plan.

3. Coordinated Care expended significant time and resources to create HBE network plans that deliver high-quality and affordable healthcare for vulnerable, low-income individuals and families, especially those who churn on and off of Medicaid. It is able to do so, in part, because Coordinated Care is not forced to contract with Seattle Children's Hospital ("SCH") at its substantially higher rates. Coordinated Care currently has a high-quality and robust provider network, which includes over 8,000 providers and 28 hospitals. Its network includes appropriate specialists, hospital services, and ancillary services in every county for which it offers an exchange plan. Enrollees are able to obtain all covered services without unreasonable delay.

4. The OIC initially declined to approve Coordinated Care's plan because of, among other reasons, an alleged absence of pediatric specialty providers within Coordinated Care's proposed network. The OIC noted Coordinated Care's failure to contract with Seattle Children's Hospital ("SCH"). Coordinated Care appealed this decision with the OIC. In the appeal, Coordinated Care argued that it has an adequate network for providing pediatric services, including hospital services. After a three-day hearing, the Chief Presiding Officer agreed with Coordinated Care and ruled that Coordinated Care's network was adequate. Attached hereto as **Exhibit A** is a true and correct copy of the Final Order, dated September 3, 2013, entered by the Chief Presiding Officer in Coordinated Care's administrative appeal of the OIC's July 31, 2013 disapproval of Coordinated Care's plans. On November 15, 2013, the Chief Presiding Officer denied the OIC's motion for reconsideration of the Final Order. Attached hereto as **Exhibit B** is a true and correct copy of the Order on OIC's Motion for Reconsideration.

5. Following the issuance of the Final Order, the OIC reviewed Coordinated Care's network again and, on September 5, 2013, approved the plans. On September 6, 2013, the Washington State Health Benefits Exchange Board certified the plans for the 2014 Exchange.

6. Coordinated Care offers three separate plans on the Exchange (gold, silver, and bronze) in 14 different counties in Washington State. As a result of the federal subsidies and Coordinated Care's low prices, many of the consumers who purchase insurance through Coordinated Care (*i.e.*, many who churn on and off of Medicaid) can obtain services without charge.

7. Coordinated Care's HBE network includes an abundance of pediatric providers around the state, including pediatric specialists and four hospitals with distinct pediatric specialty care and services. Specifically, Coordinated Care's network includes the Providence Health Services/Swedish system, which provides extensive, in-depth, specialty pediatric care and comprehensive pediatric services at multiple sites statewide, including King County. Also included in the network is Providence Sacred Heart Children's Hospital in Spokane, which provides among other things specialty and comprehensive pediatric services including cancer and cardiac care, and Shriners Hospital for Children in Spokane, which provides additional specialty pediatric services.

8. The majority of pediatric care in our state can be delivered at hospitals other than SCH. Below are examples of the types of services that each of these participating hospitals provide to children:

Providence Sacred Heart Children's Hospital in Spokane	**Pediatrics at Swedish Medical Center in Seattle**	**Providence Regional Medical Center in Everett**	**Shriners Hospital for Children in Spokane**
Oncology & Hematology	Gastroenterology	Neonatal Intensive Care (Level III)	Orthopedics
Neonatal Intensive Care	Neonatal Intensive Care (Level III)	Pediatric Intensive Care Unit	Cleft Lip and Palate
Pediatric Intensive Care	Pediatric Intensive Care Unit (PICU)	Infant Special Care Unit (ISCU)	Psychology and Psychiatry
Pediatric Level II Trauma	Level II Infant Special Care Unit (ISCU)	Children's Center (for neurodevelopment)	Post-trauma Reconstruction
Neurology	Orthopedics	Providence Regional Cancer Partnership	Nutrition
Cardiac Care	Sport Medicine		Burn Care
Neurosurgery	General Surgery		Spinal Cord Injury

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Surgery	Neurology		3D Imaging
Transplant Services	Endocrinology		Research
Adolescent Medicine	Nephrology		Physical and Occupational therapy
Developmental Medicine	Urology		Limb lengthening surgery
Endocrinology	Ear, Nose and Throat		Orthotics and prosthetics
Genetics	Epilepsy		Pain management
Nephrology	Infectious Disease		Speech therapy
Palliative Care	Emergency Room		Care coordination
Psychiatry	Therapy Services		Child life & recreation therapy
Pulmonary	Growth and Integrated Nutrition (GAINS)		Fitness training
Research	Nutrition		
Urology	Hospitalists		
Emergency	Thyroid Program		
Gastroenterology	Procedural Sedation		
	Child Life Specialists		

9. Coordinated Care did not contract with SCH for its Exchange offerings because SCH would only accept full commercial rates, the highest payment rates available. On a cost per day basis, SCH is at least two times the rates paid at other facilities for similar services. Paying those rates would unnecessarily drive up the overall cost of the product to consumers.

10. The absence of SCH from Coordinated Care's HBE network does not mean that Coordinated Care will not utilize SCH's services when necessary to provide covered benefits to its enrollees. As with any network, there may be rare or unique types of care that are not provided by the providers in Coordinated Care's network. In those cases, the service is covered through a single case agreement. Pursuant to such single case agreements, individuals enrolled in a plan with Coordinated Care can receive necessary services from out-of-network providers (such as SCH) if no in-network providers can provide the service, and Coordinated Care will reimburse the out-of-network providers for those services at no added expense to the enrolled member. These agreements are not necessarily negotiated in advance. Indeed, in some cases, Coordinated Care is simply billed for the service. Coordinated Care can later negotiate the costs with the provider or pay the invoiced amount. Single case agreements are standard practice in

the industry and are a seamless process to provide necessary care through out-of-network providers. A common example is when a consumer is traveling out of his own service area and needs emergency services from an out-of-network provider.

11. Single case agreements do not result in any consumer risk, whether in terms of access to care or additional charges. For example, if a member needs pediatric services only available through an out-of-network provider, that member will receive the covered benefits from the provider at the same benefit level as if the benefit were obtained from an in-network provider. Coordinated Care's members have the same coverage, deductibles, co-pays, co-insurance, and out of pocket maximums as they would if they obtained the service from a network provider. Although carrier approval for such unique care is generally required, no prior approval is required for emergency situations. And the consumer is not required to wait for Coordinated Care to negotiate a contract with the out-of-network provider prior to receiving medical services. The member simply receives the needed care. Coordinated Care intends to pay for all approved, out-of-network, covered services performed by SCH for its members.

12. Coordinated Care's health plans include the benefits and services covered by Washington's selected benchmark plan (*i.e.*, the *Innova* small group plan offered by Regence Blue Shield), as well as the services defined in Section 1302(b) of the ACA. Specifically, Coordinated Care's HBE plans include the essential health benefit categories specified in Section 1302(b) of ACA including, but not limited to, ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care, mandated benefits pursuant to Title 48 RCW enacted before December 31, 2011. Coordinated Care has contracted with multiple providers to develop a comprehensive provider network that is capable of providing all essential health benefits, including pediatric services, without SCH's inclusion.

13. Coordinated Care's plans also 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 service areas in Coordinated Care's HBE plans. As shown by its QHP applications, Coordinated Care's HBE plans demonstrate that at least 20 percent of available essential community providers ("ECP") in the plans' respective service areas participate in Coordinated Care's provider networks. Coordinated Care's plans also offer contracts prior to the coverage year to (1) all available Indian providers in the service area, using the model QHP addendum for Indian providers developed by CMS; and (2) at least one ECP in each ECP category in each county in the service area, where an ECP in that category is available.

14. Over 7,000 people are enrolled in Coordinated Care's plans to date. We expect to have over 9,000 enrolled on February 1, 2014.

I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct to the best of my knowledge.

SIGNED at Tacoma, Washington this 17th day of January, 2014.

Jay Fathi, MD

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Exhibit A

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BEFORE THE STATE OF WASHINGTON
OFFICE OF INSURANCE COMMISSIONER

In the Matter of	**Docket No. 13-0232**
COORDINATED CARE CORPORATION,	**FINDINGS OF FACT, CONCLUSIONS OF LAW AND FINAL ORDER**
A Health Maintenance Organization.	

TO: Jay Fathi, M.D., President and Chief Executive Officer
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Pursuant to RCW 34.05.434, 34.05.461, 48.04.010 and WAC 10-08-210, and after notice to all interested parties and persons the above-entitled matter came on regularly for hearing before the Washington State Insurance Commissioner commencing at 9:00 a.m. on August 26, 2013, and continued on August 27 and 28, 2013 until its conclusion. All persons to be affected by the above-entitled matter were given the right to be present at such hearing during the giving of testimony, and had reasonable opportunity to inspect all documentary evidence. The Insurance Commissioner appeared pro se, by and through Andrea Philhower, Esq., Staff Attorney, and Charles Brown, Senior Staff Attorney, in his Legal Affairs Division. Coordinated Care Corporation appeared by and through its attorneys Maren Norton, Esq. and Gloria Hong, Esq. of Stoel Rives LLP.

NATURE OF PROCEEDING

The purpose of the hearing was to take testimony and evidence and hear arguments as to whether the Insurance Commissioner's July 31, 2013 disapproval of Coordinated Care Corporation's form, rate and binder filings submitted on July 25, 2013 for its Bronze, Silver and Gold Individual Plan Filings (Health Maintenance Organization Agreements) for 2014 sales through the new Washington State Health Benefits Exchange was in compliance with applicable rules and therefore the disapproval should be upheld, or whether the disapproval was not in compliance with applicable rules and therefore should be set aside.

FINDINGS OF FACT

Having considered the evidence and arguments presented at the hearing, and the documents on file herein, the undersigned presiding officer designated to hear and determine this matter finds as follows:

1. The hearing was duly and properly convened and all substantive and procedural requirements under the laws of the state of Washington have been satisfied. This Order is entered pursuant to Title 48 RCW and specifically RCW 48.04; Title 34 RCW, and regulations pursuant thereto.

2. The Affordable Care Act ("ACA") was placed into law on March 23, 2010. [Testimony of Jennifer Kreitler, Senior Insurance Policy and Compliance Analyst, Rates and Forms Division, Office of the Insurance Commissioner.] Very briefly, the ACA mandates a much wider accessibility to health care coverage in all states through the availability of health plans contemplated in the ACA (identified as "Exchange Plans"). In compliance with the ACA's mandate, Washington state has chosen to have its state Exchange plans governed by a public/private partnership called the Washington State Health Benefits Exchange ("Exchange"). Under this process, disability carriers, health maintenance organizations and health care service contractors licensed by the Washington State Insurance Commissioner ("OIC") who wish to sell health plans to Washington residents through the Exchange must submit their form, rate and

binder filings pertinent to each plan they seek to sell, to the OIC. The OIC is responsible to review the form, rate and binder filings for each plan and 1) apply the federal rules pertaining to Exchange plans and also 2) apply the correct provisions of the Washington State Insurance Code and regulations which pertain to the particular type of health contract being filed for approval (e.g., disability insurance contract, health maintenance organization agreement, health care service contract). If the OIC determines that these filings comply with federal and state statutes, regulations, guidelines and interpretations thereof, the OIC is to approve these filings and transmit them to the Exchange. The Exchange then reviews the filings, certifies them as Exchange products if appropriate, and sends them to the federal government with the advice that those certified filings will be the Exchange plans which carriers will offer in this state through the Exchange. [Testimony of Kreitler.]

3. The ACA includes time frames for states' compliance which are fairly short given that the ACA requires that carriers wishing to sell their plans through the Exchange must 1) submit their form, rate and binder filings relevant to each plan to the OIC for approval; 2) have them comprehensively reviewed by the OIC; 3) have them approved by the OIC; 3) have them certified by the Exchange; and 4) have them approved by the federal government, all in time to have them on the market in this state by October 1, 2013. As part of its review process, the OIC and all states are required to apply federal rules and interpretations in developing their own procedures for filing and review of these proposed Exchange Plans. In addition, beginning some time after enactment of the ACA, on 100 or more occasions the various federal agencies and divisions of the federal government have drafted, adopted and even amended federal regulations, held meetings with states by telephone, webinar and in person, and have published and distributed guidelines, question and answer series and other materials interpreting the requirements of the ACA and have published later documents changing their interpretation of some of the federal rules and including different or new requirements for states to receive, understand and apply in their review of Exchange filings. [Testimony of Kreitler.] For this reason, states have been challenged to remain current in receiving, clarifying and applying these federal rules in the states' review process. Changes have been received by the OIC from the federal government since at least 2012 through at least June 2013. [Testimony of Kreitler.] For these reasons, and specifically because the federal government did not finally establish clear deadlines for this process for some time, the OIC was unable to provide clear deadlines to carriers for filing with the OIC until December 2012 and carriers could not make their initial filings for comprehensive review and approval by the OIC until April 2012. [Testimony of Kreitler.] In addition, while it has no authority to adopt regulations because it is not a public agency, the Exchange did establish its own guidelines for compliance, requiring the OIC to have reviewed, approved or disapproved, and submitted those approved filings to the Exchange for certification by July 31, 2013 so that it could review and submit them to the federal government in time to meet its own deadline. Apparently, however, according to statements made by OIC counsel during the hearing, the Exchange has extended its deadline for the OIC to submit approved plans to the Exchange from July 31 until September 4 and thereby has implicitly extended the July 31 deadline for carriers to submit/amend filings with the OIC and for the OIC to approve them.

4. Since enactment of the ACA, the OIC has presented many training sessions, presentations, publications and personal assistance to carriers to inform them about what these Exchange plans must include and how their form filings, rate filings and binders should be filed with the OIC. Indeed the OIC has presented sessions and distributed publications on the federal changes when they have occurred as well. [Testimony of Kreitler; Ex. 20, OIC's List of Training Seminars with dates presented; Exs. 21 through 38, OIC publications assisting carriers in making Exchange plan filings from June 6, 2012 to current.] Of significance, in presentations and publications, the OIC cautioned carriers to concentrate on making certain they had adequate networks associated with the Exchange filings. [Testimony of Kreitler; Ex. 23, p.22, July 10, 2012 OIC publication to carriers.]

5. Coordinated Care Corporation ("Company") was formed in 2012 and is authorized by the OIC to do business in Washington as a health maintenance organization. To date, the Company has offered and sold health plans associated with Washington's Medicaid programs. Although the Company has not submitted filings for, or conducted, health maintenance organization agreements outside of the Medicaid arena in Washington state before, the Company has had Exchange plans certified and approved by other states. In addition, its parent company is Centene, a large Indiana health care entity with health plans currently approved and being sold in many states (although not Washington). [Testimony of Dr. Jay Fathi, President and CEO, Coordinated Care Corporation.]

6. One or more representatives of Coordinated Care Corporation ("Company") attended all training sessions presented by the OIC. [Testimony of Kreitler.] In addition, the Company hired consultant Ginny McHugh of McHugh Consulting Firm to assist it in preparing its form, rate and binder filings for the OIC's approval to sell through the Exchange. [Hereinafter, the Company's form, rate and binder filings submitted to the OIC for approval to sell through the Exchange are referred to collectively as the Company's "filings" or "filing" unless otherwise noted.]

7. On or about December 6, 2012 the OIC published its "key dates for filings" providing that carriers could make their first filing on April 1, 2013 with the form, rate and binder filings all completed by May 1 and specified that July 31 would be the OIC's final date for approval of the filings. [Testimony of Kreitler.] These dates were not firm deadlines, but just suggested by the OIC. [Testimony of Kreitler.] Therefore, carriers had four months under these guidelines to file and have their Exchange filings approved by the OIC. [Testimony of Kreitler.] In fact, the OIC moved these timelines by Beth Berendt, then Deputy Commissioner of the OIC's Rates and Forms Division, to as late as possible because many carriers had problems with their filings, e.g., developing their networks. [Testimony of Kreitler; Ex. 21, pgs. 15-20.]

8. In compliance with the timelines published by the OIC in December 2012, the Company made its first filing with the OIC on the first day carriers were able to submit their filings, April 1, 2013. [Ex. 40.] This filing was "not accepted" by the OIC on April 3. The technical reason for this action was that the company code was not correctly specified and so apparently the OIC System for Electronic Rate and Form Filing ("SERFF") could not download the filing. Filings with the OIC are required to be made on the OIC's SERFF computer system, a national system

adopted by all 50 state insurance departments to use; the goal of SERFF is ease of filing for both carriers and the state. (The OIC also requires filings by .pdf so the filings are available for public disclosure.) For this reason, the filings were not even transmitted to OIC staff reviewing these filings. [Ex. 40; Testimony of Kreitler.]

9. The Company made a new filing (its second filing) on April 4 and the OIC disapproved and closed this filing on April 23. The Company had changed the company code to one that was recognizable by the OIC and the SERFF system. However, the filing was made as if the Company were licensed as a disability insurance company and the filing was a disability insurance policy, with the drafter applying the sections of the Insurance Code and regulations specifically pertaining to disability insurance policies when in fact the Company is only licensed as a health maintenance organization and so authorized only to file health maintenance organization agreements which are subject to different sections of the Insurance Code and regulations. [Ex. 40; Testimony of Kreitler.] Because these two types of health contracts are so different, the OIC could not conduct a comprehensive review of this filing. [Testimony of Kreitler.] In response to Exchange filings, the OIC sends Objections letters to carriers whose filings appear to the OIC to be close to approvable, stating the OIC's objections and allowing the carrier a window of time in which to address the objections by amending the wording of their filings. If the OIC believes the filings are not close to approvable due to, e.g., too many OIC concerns, then the OIC simply sends the carrier a Disapproval Letter and closes the filing, which requires the carrier to make a new filing if it chooses to continue to pursue approval. [Testimony of Kreitler.] Two or three Objection Letters are commonly sent relative to a single filing and at times nine to ten Objection Letters are sent. The Company asserts, and it was uncontested, that Group Health Cooperative received some eight Objection Letters in the course of its Exchange filings; as shown below, the Company received just one, on July 25, 2013 when the deadline for making the required changes and having the filing approved was July 31, 2013.

10. The Company made a new filing (its third filing) on May 2 and the OIC disapproved and closed this filing on May 10. As with its April 4 filing, this filing was made applying those sections of the Insurance Code and regulations pertaining specifically to disability insurance policies and not applying those sections of the Insurance Code and regulations pertaining to health maintenance organization agreements, and the filing included brackets which were not allowed in such filings. [Ex. 41, Testimony of Kreitler.] The OIC staff did, however, conduct a complete review of the filing including a first network review, and was able to identify various categories of concern about the filing, most specifically the adequacy of the Company's network. [Ex. 42.] On May 10, Beth Berendt, Deputy Commissioner for Rates and Forms, contacted the Company and arranged for a meeting to be held between the OIC and the Company. Deputy Commissioner Berendt, Kreitler and perhaps other OIC staff met with the Company staff and also its hired consultant Ginny McHugh on May 13. The OIC addressed some of its concerns in general categories but did not go through each concern due to time limitations. The OIC expressed concern about the Company's network. The Company was the only carrier proposing to construct its own network, which it believes will keep costs for consumers down, rather than "rent a network" as the other carriers did. [Testimony of Kreitler; Ex. 42, Kreitler's notes from May 13 meeting.]

11. At or before this time, it was undisputed that the OIC suggested that at least for the first year the Company should "rent a network" because the time frame for approval was short and to review the network adequacy of the Company – when it did not "rent a network" – was much more time intensive than if the OIC simply had to identify the network rented and approve its adequacy by already knowing the extent and nature of that rented network. Although the Company considered this suggestion, because its plan model includes its building its own "narrow network" – and thereby keep its rates for consumers less than the Company's commercial carrier counterparts – the Company determined to continue to build its own network. [Testimony of Jay Fathi, President and CEO of Coordinated Care Corporation; Testimony of Ross.]

12. The Company made a new filing (its fourth filing) on May 31 and the OIC disapproved and closed this filing on June 25. [Ex. 43; Testimony of Kreitler.] Although the Company had removed the brackets in this new filing it had mistakenly left one or two brackets in. Although the OIC knew the Company intended to delete all brackets in this filing, the OIC felt it could not delete them itself. [Testimony of Sara Ross, Manager of New Products and Program Operations, Coordinated Care Corporation; Testimony of Kreitler.] In addition, the OIC conducted a second network review. [Testimony of Kreitler.]

13. On June 27, Kreitler and perhaps other OIC staff again met with the Company, discussed its position that the remaining bracket(s) were prohibited and again raised its concern about the adequacy of the Company's network. [Testimony of Kreitler; Ex. 44, Kreitler notes from June 27 meeting.]

14. The Company made a new filing (its fifth filing) on July 1. In response to the OIC's continuing concerns about the Company's network adequacy, the Company contracted with Healthway, a network of some providers it would "rent" in order to address the OIC's concern that the network the Company had constructed was inadequate as to some types of providers. The Company submitted this Agreement to the OIC on July 9, 2013 to be considered along with its May 31 filing. [Ex. 48, Network Access Agreement between the Company and Healthways WholeHealth Network, Inc. ("Healthways").] Healthways is a network other carriers current "rent" as well. On July 10 the OIC conducted a third network review, wrote a Network Review report on that date and provided this report to the Company on July 11. [Testimony of Kreitler; Ex. 45, OIC's Network (Form A) Review dated July 10.] The Company responded to the OIC's Network Review on July 15. [Ex. 46, Company's Response to OIC's Network Review.] Through this process, including an earlier June 28 email between the parties [Ex. 47, June 28 email], the parties were able to resolve many of the OIC's issues about the Company's network adequacy [Testimony of Kreitler] and on July 15 the Company submitted its Access Plan to the OIC. [Ex. 2, Company's Geo Network Report indicating location of pediatric specialty hospitals and Access Plan.] The OIC apparently still had some concerns, however, as shown below.

15. The OIC did not disapprove and close the Company's July 1, 2013 filing after review, but instead wrote the Company an Objection Letter dated July 17 containing numbered Objections to

the Company's July 1 rate filing and binder, and on July 22 wrote the Company an Objection Letter to the Company's form filings. [Testimony of Kreitler; Ex. 57, OIC's Objection Letter re Company's rate filing; Ex. 52, OIC's Objection Letter re Company's Binder filing; Ex. 53, OIC's Objection Letter to Company's rate filing.] As detailed above, the purpose of an Objection Letter is - instead of simply closing the filing on the date of disapproval - to provide carriers with the reasons why their filings were not approved and to allow those carriers a period of time to remedy these objections (by e.g., furnishing new language or more justification for their the currently filed language) and to thereby have those current filings approved. [Testimony of Kreitler.]

16. When the Company received the OIC's July 17 and 22 Objection Letters to its July 1 filing, under the current guidelines from the Exchange it had only until July 31 to file changes, provide explanations and otherwise remedy the OIC's objections. Accordingly, after receiving the OIC's July 17 and 22 Objection Letters, on July 25 the Company made changes and/or provided additional justification to its July 1 filing in a prompt attempt to address the OIC's concerns expressed in these Objection Letters. [Testimony of Fathi; Ex. 58, Company's 7/25 response to OIC objections re rate filing; Ex. 56, Company's 7/25 response to OIC objections re binder filing; Ex. 54, Company's 7/25 response to OIC objections re form filing.]

17. The Company resubmitted its July 1, 2013 filing on July 25 with changes the Company believed the OIC required based on the language of the OIC's July 17 and 22 Objection Letters and prior communications with the OIC. [Testimony of Ross; Testimony of Fathi; Ex. 25.] However, on July 31, the OIC disapproved the Company's filings yet again (these filings being those originally filed July 1 and resubmitted with OIC's required changes on July 25), for reasons set forth in the OIC's Disapproval Letter to the Company dated July 31. [Ex. 4, OIC's Disapproval Letter dated 7/31/13.]

18. As of the July 31 date the OIC disapproved the Company's filings, the OIC maintained that the OIC could not accept more amendments or new filings from the Company, for the reason that the Exchange had set July 31 as its deadline for the OIC to submit approved filings to it.

19. Since July 31, 2013 when it received telephone notice that its July 25 filings had been again disapproved, the Company has been attempting to communicate with the OIC to clarify some of the reasons for the OIC's disapproval as stated in the Disapproval Letter dated July 31, and to find out what it can do to address the OIC's reasons for disapproving its filings, e.g., change language in the filing/provide additional justification for its language, etc. However, it is uncontested, and is here found, that the OIC has been unwilling to communicate with the Company since the July 31 date of disapproval. [Testimony of Fathi.]

20. Thereafter, on August 13, 2013 the Company filed its Demand for Hearing to contest the OIC's disapproval of its July 25 filings. [Ex. 1, Demand for Hearing dated August 13, 2013.] The Company also attempted to schedule a meeting to communicate with the OIC to clarify what it could do to address the OIC's remaining reasons for disapproving its July 25 filings. At that time, and as OIC counsel agrees, the OIC advised the Company that the OIC was prohibited

from communicating with the Company because the Company had filed a Demand for Hearing and so now the parties were in litigation; because the parties were in litigation, the OIC advised the Company, the OIC was prohibited from communicating with the Company (apparently even if the Company had its attorney present). No reason was given why the OIC refused to communicate with the Company from July 31 when the OIC disapproved its filings until August 13 when it filed its Demand for Hearing. [Testimony of Fathi.] In addition, the OIC states that it is prohibited from accepting new filings after July 31 and so, the OIC argues, when the OIC disapproved the Company's filing on July 31 there was no opportunity for the Company to amend the filing, or make a new filing, to address the OIC's either continuing or new reasons for disapproval set forth in the July 31 Disapproval Letter. [Testimony of Fathi.] However, the Company testified at hearing, and it was acknowledged by OIC counsel, and is therefore here found, that the OIC has in fact entertained communications, settlement negotiations and new/amended filings with other similarly situated carriers whose filings it disapproved on July 31 even though it has refused to allow any communications with Coordinated Care. [Testimony of Fathi.] When questioned about whether the OIC is not violating its own stated policy prohibiting it to communicate/negotiate with carriers in litigation, the OIC then changed its reason for not communicating with Coordinated Care: the OIC states that it has chosen to communicate only with those carriers whose filings appear to the OIC to be close to being able to be approved. In addition therefore, the OIC would then also be allowing those selected carriers to make new filings after the July 31 deadline in violation of its own stated rule. While there may be some justification for distinguishing between carriers in this way, the OIC would not state how many other carriers were selected for additional negotiation or how many others were being treated in the same manner in which Coordinated Care is being treated, yet the OIC did advise that it selected those carriers with which to continue negotiations based upon the OIC's appraisal, on or about July 31 after it disapproved all or most of the subject filings, of how far apart each carrier was from the OIC's requirements: whether that is sufficient justification is not the subject of this proceeding. Finally, no authority was presented as to how the OIC could violate its stated policy of not communicating with carriers in litigation as to some carriers but not with Coordinated Care, and how it could allow some carriers to violate the OIC's stated filing deadline of July 31 but not Coordinated Care. Coordinated Care argues that it is being treated unfairly in comparison with other carriers. [Coordinated Care Prehearing Brief filed August 26; Testimony of Fathi.]

21. The OIC believes it is possible that Objections 6, 7, 8, 9, possibly 11 and possibly 12 of the total of 15 Objections which were the bases of its disapproval of the Company's July 25 filings could be redrafted and/or reworked so that these filings could be approved. The OIC would have allowed the Company more time to redraft and/or rework these sections had it felt there was enough time before July 31 to accomplish this work and approve the filings. [Testimony of Kreitler.]

22. The OIC believes that Objections 5, 10 and 13 of the total of 15 Objections which were the bases upon which it disapproved the Company's July 25 filings are major obstacles to these filings being approved. [Testimony of Kreitler.]

23. The OIC did not present evidence regarding the level of importance or correctability of its concerns, expressed in its July 31 Disapproval Letter, about the Company's rate filing and binder filing.

24. Contrary to the Company's assertions, there is insufficient evidence to show that the OIC intended only to approve commercial carriers or that the OIC exercised unfair treatment of some carriers over others. The OIC's actions included no intentional malfeasance or ill intent in treatment of this Company. Both the OIC and the Company were both working with their best intentions with complicated new federal laws and regulations which were constantly being reinterpreted and which included nearly impossible time frames. In short, both parties did the best they could in the circumstances with the exception, perhaps, of OIC's refusal to communicate with the Company beginning on July 31 to the current time when at the same time, it was found above, the OIC was communicating with some -- but not all – similarly situated carriers and allowing them to file amendments/make new filings after the July 31 deadline; whether or not the OIC's justification for such selective treatment is valid is not necessary to determine herein.

25. Jay Fathi, MD, President and Chief Executive Officer of Coordinated Care Corporation, appeared as a witness for the Company. Dr. Fathi presented his testimony in a detailed and credible manner and presented no apparent biases.

26. Sara Ross, Manager of New Products and Program Operations for Coordinated Care Corporation, appeared as a witness for the Company. Ms. Ross presented her testimony in a detailed and credible manner and presented no apparent biases.

27. Jason Nowakowski, a principal of Milliman, Inc. and a consulting actuary for the Company, appeared as a witness for the Company. Mr. Nowakowski presented his testimony in a detailed and credible manner and presented no apparent biases.

28. Molly Nollette, Deputy Commissioner for the Office of Insurance Commissioner, Rates and Forms Division, appeared as a witness for the OIC. Although Ms. Nollette has been in this position for just a few weeks, and therefore did not include great detail, she presented her testimony in a detailed and credible manner and presented no apparent biases.

29. Shirazali Jetha, Actuary for the Office of Insurance Commissioner, Rates and Forms Division, appeared as a witness for the OIC in regard to the OIC's review of the Company's rate filing. Mr. Jetha was not involved in the process at issue herein and was not the individual who reviewed the Company's filing. The actuary who did review the Company's rate filings, Michiou Lee, was unavailable to testify on the hearing date. Because of this, while his testimony was of less value, Mr. Jetha presented his testimony in a detailed and credible manner and presented no apparent biases.

30. Jennifer Kreitler, Senior Insurance Policy and Compliance Analyst, Rates and Forms Division, Office of the Insurance Commissioner, appeared as a witness for the OIC. Ms. Kreitler

was the analyst assigned to review the Company's filings and was the individual directly involved in each step of the OIC's review process of the Company's filings. Ms. Kreitler has substantial, detailed and current knowledge of this process. She presented her testimony in a detailed and credible manner and presented no apparent biases.

CONCLUSIONS OF LAW

Based upon the above Findings of Facts, it is hereby concluded:

1. The adjudicative proceeding herein was duly and properly convened and all substantive and procedural requirements under the laws of the state of Washington have been satisfied. This Order is entered pursuant to Title 48 RCW and specifically RCW 48.04; Title 34 RCW; and regulations pursuant thereto.

2. This matter is governed by Title 34 RCW, the Administrative Procedures Act. The parties agree, correctly, that the Company bears the burden of proof in this matter. As both parties also argue in their presentations at hearing and as case law under Title 34 RCW dictates, the standard of proof to be applied in this matter is preponderance of the evidence. Finally, as stated in the Company's Demand for Hearing, in the Notice of Hearing, as acknowledged by the OIC and also by the Company in its Response to OIC Staff's Motion to Determine Order and Burden of Proof, the central issue in this proceeding is whether on July 31, 2013 the OIC erred in disapproving the Company's binder, form and rate filings for its Bronze, Silver and Gold Individual Exchange Plan Filings for 2014. 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.

3. The OIC argues that its review of health plan filings is "Pass or Fail." In other words, the OIC argues, if one section of the filing is not in compliance with applicable statues or regulations, then the entire contract must be disapproved. In fact, the OIC argues that it has no authority to approve a plan which contains even one section which is noncompliant, and argues that it has no option but to disapprove the plan filing. Therefore, the OIC argues, the only question for the undersigned to decide in this matter is whether every section of the Company's July 25, 2013 Exchange plan filings (those most recently disapproved) were in compliance with all applicable federal and state statutes and regulations as of July 31, 2013. The OIC argues that if the undersigned concludes that even one section of these filings was noncompliant on July 31 then the undersigned must uphold the OIC's disapproval of these filings. The OIC's argument has merit, i.e., the OIC certainly cannot approve a filing on the basis of a carrier's statement that it "intends" to contract to have certain providers in its network. However, as set forth above, the central issue in this proceeding is whether on July 31 the OIC erred in disapproving the Company's filings. This contemplates not only whether all sections of the filings comply with all applicable statutes and regulations (hereinafter collectively "rules" unless otherwise noted), but also whether the OIC's process of review was reasonable. If review were based only on whether any single section of the filings violates any rule - in complete disregard of the agency's

review process no matter what the agency did or failed to do - then one can imagine endless scenarios of agency abuse which might occur. While it has been found above that the OIC's actions included no ill intent in treatment of this Company, a determination of the central issue herein must of necessity include not only whether the filings were in compliance with applicable rules but also must include some basic consideration of the review process which the agency conducted; this is particularly true where, as here, the Company raises significant issues regarding the review process and claims that process unreasonably restricted its opportunity to have its filings approved. Indeed, while the OIC argues that the only issue is whether the Company's filings are fully compliant with all applicable rules, at the same time the OIC spent far more time – literally hours – presenting written documents and oral testimony solely regarding its process of reviewing these Exchange filings, both in general and with regard to this Company's filings. Therefore, the OIC itself seems to contemplate that its review process is relevant to determination of the central issue herein.

4. As found above, the OIC would most likely have allowed the Company more time to amend its July 25, 2013 filings to resolve the OIC's remaining concerns had the OIC thought the Company still had time to file these amendments. However, on July 25 when the Company submitted its filings for the sixth time, including more changes it believed the OIC was requiring, because the OIC believed there was not enough time for the Company to amend its filings by the Exchange's July 31 deadline, it simply disapproved the filings. [Testimony of Kreitler.] At the same time, as found above, after the July 31 disapproval the Company contacted the OIC in a strong effort to be able to clarify the OIC's remaining concerns and to be able to file either amendments or a new filing in which the Company intended to include new revisions the Company understood the OIC required. If the OIC had been willing to communicate with the Company then , the Company would have had from July 31 to the current time (over four weeks) to make the changes it understood the OIC to be requiring, because the Exchange is still accepting approved plans from the OIC even now which is over four weeks after its July 31 "deadline."

5. The OIC had discretion to give the Company additional time to remedy the issues raised in its objections. E.g., the rules requiring health maintenance organizations to utilize SERFF are set forth in WAC 284-46A, which provides that "*The Commissioner may reject and close any filing that does not comply with WAC 284-46A-040, -050, and -060.*" [Emphasis added.]

6. RCW 48.44.020 similarly provides that "*[t]he commissioner may*" disapprove contract forms that are statutorily deficient. [Emphasis added.]

7. Further, neither the OIC nor the Exchange is precluded by federal or state law from permitting the Company to make changes following the Exchange's July 31, 2013 deadline/guideline for the OIC to send approved health plans to the Exchange for certification. Federal regulations implementing the ACA provide the Exchange with broad discretion to design processes for QHP certification, and the only applicable deadline established by federal law is that QHP certification must be completed before the start of open enrollment on October 1, 2013. 45 CFR Sec. 155.1010. And while the Exchange is required to transmit certain plan data to the

Center for Medicare and Medicaid Services ("CMS") for financial purposes, there is no deadline in federal law for when the Exchange must do so. In short, July 31 was not a federally-established deadline by which the OIC was mandated to begin 1) refusing to allow amendments to existing filings; 2) refusing to allow new filings; or 3) refusing to communicate with carriers whose filings had been disapproved by the OIC on July 31 or another time. Indeed, the OIC itself opened a submission window through August 9, 2013 for the refiling of on-exchange plans after the Exchange communicated its willingness to consider plans filed through that date. Although the OIC subsequently changed its position and decided to stay with the original July 31 deadline, that activity indicates that the OIC's and Exchange's internal deadlines are somewhat flexible. Furthermore, the Exchange Board voted at its August 21 meeting to delay certification of any filed plans until the OIC could address the pending appeals regarding the disapproved plans, agreeing to meet again on September 4, 2013. This activity indicates that the Exchange desires to provide carriers with more time to demonstrate that they can offer Exchange plans in order to provide Washington residents with adequate health insurance options. The Exchange's actions suggest that it is willing to exercise flexibility to ensure that the greatest number of conforming plans can be offered on the Exchange.

8. The OIC's discretion to accept filings after July 31 also extends to allowing carriers the opportunity to edit contract language and plan data after submission. Indeed, federal law provides a model for this, providing a period of time expressly intended for the correction of errors in plan data following submission of data to CMS which is called the "Plan Preview" process.

9. The OIC's advice to the Company that it was prohibited from communicating with the Company because the Company had filed a Demand for Hearing is not supported by law. Applicable law allows the OIC staff (not formal counsel) to communicate with entities after they have filed a Demand for Hearing although courtesy – not law – might require that the OIC staff communicate only in the presence of (or with the permission) of the entity's attorney. Perhaps the OIC meant that its policy, not a law, was to refuse to communicate with entities after they have filed a Demand for Hearing; if this is the situation, although it would regrettably impede any possibility of settlement, the OIC should have made it clear to the Company that it has a policy of refusing to communicate after a Demand for Hearing is filed because to advise that a law prohibits the OIC from such communication is disingenuous.

10. When reviewing the OIC's reasons for disapproval of these filings as set forth in its July 31, 2013 Disapproval Letter, the Company's evidence showed that the Company does not disagree with the amount and type of coverage which must be covered. The parties' differences were in those sections where the Company believed its language was clear and the OIC did not believe it was clear. While the OIC's reasons for disapproval of several sections were valid in that the language is indeed unclear and/or misleading (see below), in each case both parties intend the same result and the Company has stood ready to amend its language to meet the OIC's concerns since July 31. As found above, the OIC has selected some other carriers with which it will communicate – and has communicated – after July 31 and is allowing those other carriers to make changes after July 31 to remedy the OIC's concerns expressed in their July 31 Disapproval

Letters. While this selective process may have reasonable bases, the recognition that the differences between the OIC's concerns and the Company's positions - including its willingness to amend its language to address the OIC's concerns – leaves this selective process in question in this specific situation. Therefore in order to ensure the Company is given similar opportunities to amend its language as other carriers have been given, the parties should promptly work together to amend the Company's language to the satisfaction of the OIC but applying the guidance in the Conclusions below. Further, the OIC should allow amendments to its July 25 filings (including allowing a new filing to be made if that is the proper mechanism to allow amendments since the OIC actually disapproved this July 25 filing on July 31) so that the Company has the opportunity - along with other similarly situated carriers whose filings were disapproved on July 31 and at least some of whom also appealed their disapprovals - to have its filings approved. Said conference between the parties on the wording of these sections, filing of amendments/new filing and approval should be done promptly so that the Company's filings might be approved and presented to the Exchange for certification for sale in 2014. While approval of the Company's filings is still within the authority of the OIC, the review process at this point must be governed by the Order herein. The OIC is expected to incorporate the Conclusions below, immediately meet and/or otherwise communicate with the Company to discuss OIC's remaining concerns, review language, provide recommendations for language to the Company and review the Company's filings (incorporating the Conclusions below into the OIC's requirements). Given that the Company has indicated it is anxious to make the amendments the OIC requires - and just asks that the OIC make clear what changes it is requiring (so long as they are consistent with the Conclusions below) so that it can make the changes - it is expected that the OIC can approve these filings in short order provided the Company does make the changes the OIC requires at this time.

11. As above, the OIC believes that Objections 6,7, 8, 9, and possibly 11 and 12, of the total of 15 Objections which were the bases of its disapproval of the Company's July 25 filings could be redrafted so that these filings could be approved. [Testimony of Kreitler; Ex. 4.]

> *6. The "Adding An Adopted Child" provision is still too restrictive in conflict with RCW 48.01.180 and RCW 48.46.490. First, it is unclear why* [the Company] *has added additional language defining conditions of "placement". Second, it is unclear what the "written notice" is a parent must provide regarding the intent to adopt the child. The enrollee is only required to apply for coverage for the new dependent.*
>
> While the OIC's above reason for its disapproval of this section is unclear, at hearing the OIC advises that at this time its only objection is that the Company needs to require the consumer to send an "application" to the Company to secure coverage rather than requiring to send the Company "written notification." However, the applicable statute, RCW 48.46.490, requires the consumer to provide "written notice" to the Company. Indeed, requiring "written consent" is actually less restrictive for the consumer and not more restrictive. Therefore, that remaining portion of OIC's Objection No. 6 is of no merit and the Company is in

compliance with RCW 48.46.490. In its testimony the OIC presents no other remaining argument that this section is noncompliant.

7. The "For Dependent Members" provision is too restrictive and contains language that may conflict with RCW 48.46.320. A carrier may not require a dependent child be "...continuous total incapacity..." to qualify for coverage.

While the OIC's above reason for disapproval of this section is unclear, both parties intended that these plans cover dependent members as required by RCW 48.46.320. While the Company asserts it intends to cover dependent members in all situations required by RCW 48.46.320, the OIC's concern is valid: the current language is unclear and leads the consumer to believe that a dependent child over age 26 can remain on the parents' policy only if that child had a "continuous total incapacity." To provide clear language that indicates that dependent member coverage is broader and in compliance with RCW 48.46.320, the OIC should promptly review and/or suggest amended language which would meet its concern that the current language is misleading.

8. The "Family Planning Services" provision is too restrictive per RCW 48.46.060(3)(a) and (d) and A.C.A. A carrier may not place restrictions on access to any FDA approved contraceptive drugs or devices.

While it was not clear in the OIC's July 17, 2013 Objection prior to disapproving the filing or in its July 31 Disapproval Letter, in its brief and at hearing the OIC argues that this provision violates RCW 48.46.060(3)(a) and (d) and the ACA in that a carrier may not place restrictions on access to any FDA-approved contraceptive drugs or devices and the Company's proposed method of limiting provision of brand name drugs vs. generics is appropriate but when it does this it must still accommodate any individual for whom generic drugs or brand name drugs would be medically inappropriate. Therefore, the OIC advises the language must include a mechanism for waiving the otherwise applicable cost-sharing for the branded or non-preferred brand version in these situations and the Company's contract does not. The Company does not disagree, arguing that its language does not place restrictions on access to any FDA approved contraceptive drugs or devices, and under a plain reading of this provision all "prescription drug contraceptives" are covered under the plan without exception. The Company also argues that the note at the bottom of that contract page also does not limit the types of services and, to the contrary, it explains to the consumer how she can have prescription birth control pills covered at 100% rather than the cost-sharing percentage normally required for these types of drugs. While the OIC's objection about lack of waivers for cost-sharing is new as of July 31, the Company believes that is already addressed to the extent it is required. The OIC should promptly review and/or suggest amended language which would meet any remaining

concerns that the current language is misleading or does not comply with RCW 48.46.060(3)(a) and (d) and the ACA.

9. The "Home Health Care Service Benefits" provision is too restrictive in conflict with WAC 284-43-878(1) because it contains limitations services and supplies that may be required to provide medically necessary care in a home setting.

The OIC first brought up the fact that its concern here was that this section unreasonably limits the type of durable medical equipment covered for individuals on home health care in its pre-hearing brief filed long after the date of its disapproval of these filings. Prior to this time, the OIC's concern had been in regard to Ambulatory Care and not Home Health Care Service Benefits. [Ex. 53, July 22 OIC Objection Letter.] However, directing the OIC's concern relative to the Health Care Service Benefits provision, the OIC's argument that this provision is misleading is valid. As the OIC asserts, this issue would be fairly quickly cured if the Company cross-referenced this section and the Durable Medical Equipment section of the contract or otherwise made minor changes to this wording so it is clear that an adequate amount and variety of durable medical equipment is covered in this contract for individuals on home health care. The OIC should promptly review and/or suggest amended language which would meet its valid concern that the current language is misleading or does not comply with WAC 284-43-878(1).

11. The Pharmacy benefit defines Mail Order drugs have a "3 times retail cost sharing" requirement. This language is confusing and ambiguous per RCW 48.46.060(3)(a). You must specifically define the cost share obligation to the member in the policy.

While the OIC raised this concern for the first time in its July 31, 2013 Disapproval Letter, the Company advises that the OIC has mistakenly characterized this coinsurance maximum as a deductible which it is not, that the $350 does not represent a deductible nor is it an additional amount that is charged to the consumer. Here, the consumer would be obligated to pay a certain percentage of the bronze product and specialty drugs under the policy regardless of this provision and the maximum just places a cap on that amount. It has no impact on the deductible; coinsurance is paid in addition to the deductible. Therefore, the Company argues that it has not obligation to make any revisions to the filings. The Company's interpretation of the requirements of RCW 48.46.060(3)(a) appear reasonable. If, however, there is any language which the OIC believes would make this provision more clear to the reader then the OIC should promptly review and/or suggest amended language which would meet any

remaining concerns that the current language is misleading or does not comply with RCW 48.46.060(3)(a).

12. The "Premiums" section is still too restrictive in conflict with RCW 48.43.005(31).

While the OIC is correct that the wording in this section is misleading at best and is a major concern, at the same time it can be quickly corrected,. The OIC raised this concern for the first time in its Hearing Brief. [OIC Hearing Brief, p. 18.] As argued there, the OIC believes that the Premiums section of the contract violates RCW 48.43.005(31) and RCW 48.46.064(1)(a) because 1) the inclusion of the phrase "[f]rom time to time, we will change the rate table used for this contract form" is not a true statement because rates may only be changed yearly. The OIC is correct and this concern is valid. The OIC also argues 2) that the inclusion of the phrase "[t]he 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" is incomplete because it does not expressly list the five reasons included in RCW 48.46.064(1)(a)(i-v). The OIC is correct and this concern is valid. While the Company argues that neither concern is valid, had the OIC advised it that it required a change in this language it would have done so quickly. As above, the Company should be given the time to promptly change the wording in 1) above to make clear that the rates for the contract can change only yearly, and 2) to advise the consumer all the factors considered in determination of rates (by cross-reference or other means).

12. The OIC believes that Objections 5, 10 and 13 of the total of 15 Objections which were the bases upon which it disapproved the Company's July 25 filings are major obstacles to these filings being approved. [Testimony of Kreitler.]

5. The definition of eligible service is confusing and misleading [RCW 48.46.060(3)(a)] *because it does not clearly notify the enrollee that in addition to in-network cost-share requirements they will be subject to "balance billing" by the provider or facility.*

This is the network adequacy issue, which was the subject of very substantial evidence presented by both parties. As found above, the OIC conducted two Network Reviews of the Company's network, and on July 10, 2013 conducted another Network Review, had multiple discussions with the OIC about its requirements and remaining concerns, filed its Network Access Agreement with Healthways which "rented" some network providers such as other carriers were doing, filed its Network Access Plan with the OIC, and were by these efforts able to clear up many of the concerns the OIC had with the Company's network adequacy. After lengthy argument and testimony, at hearing the OIC advised that its remaining concerns about this issue are 1) the Company has no massage

therapists in its provider network; 2) the Company has no Level 1 Burn Unit or pediatric specialty hospitals in its network; and 3) the Company is not allowed to use "spot contracts" or "single payer agreements" to complete its network of providers because, e.g., the Providers under the Company's plan are prohibited from balance billing the consumer (which those "spot contract" providers would do).

a) No massage therapists in network. Massage therapists are included in the Company's network as required. This has been done through the Company's Network Access Agreement with Healthways. By either July 30 or 31 – i.e. before disapproval of the filings – the Company's Network Access Agreement with Healthways had been deemed approved by the OIC pursuant to RCW 48.46.243(3)(b). Although the Plan Summary did not include massage therapists when describing the Healthways providers available to the consumer, the Plan Summary is not part of the contract between the Company and Healthways. However because the Plan Summary does provide information to the consumer and does mistakenly fail to include massage therapists in its list of included providers, the Plan Summary must be corrected immediately to clarify that the Company's network (through Healthways) does in fact include massage therapists.

b) Lack of specialty hospitals providing Level I Burn Unit and pediatric services in network. As the Company argues, carriers are not required to include Level I Burn Units or pediatric hospitals in their networks. Rather, pursuant to WAC 284-43-200, carriers are required to include sufficient facilities to ensure that all health plan services, including Level 1 burn services, are accessible to consumers without unreasonable delay and within reasonable proximity to the business or personal residence of covered persons, taking into consideration the relative availability of health care providers or facilities in the service area under consideration and the standards established by state agency health care purchasers (such as the Medicaid program in which the Company currently participates). Under WAC 284-43-200(2), sufficiency and adequacy of choice may be established by the carrier with reference to any reasonable criteria, including provider-covered person ratios by specialty, primary care provider-covered person ratios, geographic accessibility, waiting times for appointments with participating providers, hours of operation and the volume of services available to serve the needs of covered persons requiring this specialty care. WAC 284-43-200(2) provides that evidence of compliance with the network adequacy standards that are substantially similar to standards established by state agency purchasers (e.g. Medicaid) may also be used to demonstrate sufficiency. For these reasons, and the fact that the Company's network is substantially similar to the

standards established by Medicaid - which the OIC agrees it does, and which is demonstrated in its Network Access Plan – the Company has shown that its network is adequate as to these specialty demonstrates its network sufficiency. .

c) The OIC argues that the Company is not allowed to use "spot contracts" aka "single payor agreements" to complete its network of providers. The OIC argues that this prohibition is primarily because the consumer is not protected in those situations from being balance billed by the provider hired under the "single payor agreement." Further, the OIC argues that the Company's contract language does not protect the consumer from balance billing either. Virtually all carriers on occasion use "single payor arrangements" in provision of network services, e.g., when the consumer is traveling out of his own service area; in the case of an emergency; when the type of services rendered by that provider are not commonly required. Indeed, at hearing the OIC read language from a Regence health contract which specifically allowed for such "single payor agreements" and described one such type of services as those rendered by pediatric specialty hospitals. [Testimony of Kreitler.] 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 and within a reasonable area, and it permitted 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. Therefore, by this showing, and by the fact that the Company's plan is substantially similar to its Medicaid network, the Company is not required to have included pediatric specialty hospitals or Level I Burn Units within their provider network.

However, the OIC is correct that the Company's contract language is unclear about the fact that the consumer cannot be subject to balance billing in any situation, whether the provider is one working through an "individual payor agreement" with the Company or whether the provider is a regular Company network provider or whether the provider is a Company network provider through Healthways. The Company must promptly change its contract language in this section to clearly inform the consumer that he is protected from balance billing in all of these situations. Clear language which has been deemed approved by the OIC is found in the Regence contract read into the record at hearing. Further, although the OIC does not require carriers to file their "single payor agreements" with the OIC, in this particular situation, given the OIC's concern, the Company shall promptly provide to the OIC the form of "single payor agreement" which it will use when needed; the form must include a hold harmless clause

complying with applicable rules so that the OIC has assurance that the consumer is protected from balance billing in any of these three situations.

10. The Bronze Product, Specialty Drug benefit includes a $350 maximum "eligible coinsurance charge" before the service is paid at 100%. This dollar amount is a deductible and must be set forth in the policy, rate, and binder as such. The benefit as stated in the policy is misleading per RCW 48.46.060(3)(a0 [sic].

The OIC identified this section as a concern for the first time on July 31, 2013 (apparently of necessity as this language was first included in the Company's filings in its July 25 filing). The OIC argues that the Company seeks to place a $350 deductible on specialty drugs, which deductible does not exist for other drugs and thus is illegally discriminatory against enrollees who have health conditions that require these drugs and is a violation of the community rating requirement, citing RCW 48.46.064 and WAC 284-43-877(9)(c). In addition, the OIC argues that a policy may not include a hidden deductible such as this, which misleads consumers in violation of RCW 48.46.060(3)(a). Once again, the parties do not disagree on the requirements of the rules but only on whether the wording accurately represents the statutory requirements. For this reason, the OIC should promptly review and/or suggest amended language which would meet any remaining concerns that the current language is misleading or does not comply with RCW 48.46.064 or WAC 284-43-877(9)(c).

13. The Pharmacy Benefit Template, Plants and Benefits template and policy do not match. For example, HIOS Plan ID 61836WA0030001 defines it will use Formulary ID WA F003. Formulary ID WAF003 is a 4-tier pharmacy option utilizing copay cost share requirements. The Schedule of Benefits for this Bronze Product defines certain drug tiers are subject to coinsurance [sic]. *WAF003 does not include any coinsurance requirements.*

The OIC first identified this concern to the Company in its July 31, 2013 Disapproval Letter (of necessity as apparently the template was not filed with the OIC until July 25 and up until that time this information had been provided as "TBD"). The OIC advises that this provision can be remedied if the Company changed "co-pay" to "co-insurance" in the three places identified in the contract. [Testimony of Kreitler.] Therefore the OIC should 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.

13. The OIC did not present evidence regarding the level of importance or correctability of its concerns, expressed in its July 31 Disapproval Letter, about the Company's rate filing and binder filings. They are these, in total:

1. You did not add the counties you offer these plans in onto [sic] the rate schedule or a separate document on the Rate/Rule Schedule tab.

First, the Company asserts there are no statutes or regulations that require it to include the counties offered in its plans onto a "rate schedule" or in a Rate/Rule Schedule tab, nor did the OIC provide any authority for this requirement. Second, the Company argues that the OIC has had since May 1 to identify this alleged deficiency but raised it for the first time on July 31; and had the Company been notified this was a concern it would have been easily remedied. However, the Company argues that it had already clearly identified the counties that were offered in its plan in its product submission. [Revised Product Submission, submitted July 25, 2013.] The Company also argues that the offered counties were also included in its Form A submissions with the most updated list included in the off-cycle Form A submitted July 25 and as part of its binder submission, and that therefore there should have been no question regarding which counties were included in the Company's plan. Testimony presented by the Company was persuasive and indeed, there appears to be no clear authority for the OIC to require anything further from the Company at this time. The OIC staff actuary who reviewed this rate filing presented no evidence, and little value could be placed on nonspecific evidence from an OIC actuary who had not reviewed this filing and could only testify generally. For this reason, the OIC should promptly review this requirement in light of this Conclusion.

2. You did not provide methodology, justification, and calculations used to determine the contribution to surplus, contingency charges, or risk charges included in the proposed base rates. Furthermore, your definition of "profit" and "contribution to surplus" is inconsistent with WAC 284-43-910(13).

The OIC argues that the Company failed to provide methodology, justification and calculations used to determine the contribution to surplus, contingency charges, or risk charges included in the proposed base rates. However, based upon 1) evidence and argument presented by the Company and its consulting actuary; and 2) evidence and argument presented by the OIC which lacked evidence from its reviewing actuary and presented unclear evidence from another OIC actuary who had not been involved in this review, it is concluded that the Company showed that it has provided methodology, justification and calculations as required. [Testimony of Jason Nowakowski, Principal and Consulting Actuary with Milliman, Inc. in Seattle; Testimony of OIC Actuary Shirazali Jetha.] This concern is of no validity.

3. You did not submit the calculations and justification of the area factors. You mentioned that Exhibit 3 describes the expected reimbursement level as a

percentage of Medicare and rating factors by rating area. However, there is no Exhibit 3 attached to the rate filing.

The Company did attach Exhibit 3 to the rate filing as required. [Testimony of Nowakowski; Testimony of Jetha.] This concern is of no validity.

4. You did not provide the supporting documentation and calculations for the figures used to calculate the Index Rate to Base Rate in Appendix F. You mentioned that Exhibits 4A and 4B include detailed calculations for SG&A and Licensing, Taxes and Fees. However, there are no Exhibits 4A and 4B attached to the rate filing.

The Company attached Exhibits 4A and 4B to the rate filings as required. [Testimony of Nowakowski; Testimony of Jetha.] This concern is of no validity.

14. The OIC's reasons for disapproval of the Company's Binder filing are included at Nos. 14 and 15 of its Disapproval Letter, as follows:

14. You do not rate based on tobacco use. Therefore, cell K10 should read "Not Applicable" in the Rating Business Rules template.

15. You do not have a tobacco-use factor. The Rate Data template should not include a tobacco rate column.

In its Hearing Brief, the OIC admits that these objections were "simply technical corrections." [OIC's Hearing Brief, p. 19.] Although the OIC does not cite to any statute or regulation that requires the changes it required in Nos. 13 and 14, had the OIC raised these issues prior to disapproving the filings on July 31, 2013 the Company could have remedied these issues fairly quickly. For this reason, the OIC can require the Company to make these technical corrections, but they cannot be an obstacle to approval of the Company's filings.

15. Based upon careful consideration of the evidence presented, and the arguments of the parties, and upon the above Findings of Facts and Conclusions of Law, it must be recognized that the specific situation involved in this particular review of the Company's filings is unique. This situation involves uniquely short time frames mandated by the ACA for review and approval of the Exchange filings (as opposed, e.g., to the more normal File and Use process of OIC approvals of filings); it involves uniquely complex new federal statutes which were the subject of over 100 new federal regulations, interpretations, reinterpretations and other dictates and changes thereof; and it involves already complex state rules and other uniquely difficult challenges for both the OIC, the Exchange and carriers seeking approval and certification to sell their products through the Exchange. Allowing a window of time for modifications following the submission deadline is well within the OIC's discretion and in full accord with federal rules and the clear goals of both federal authorities and the Exchange. Under the circumstances presented here,

permitting the Company to quickly make modifications as indicated above is reasonable and appropriate. For the OIC to now fail to provide the Company with a short time period, and good communication and cooperation, in order to allow the Company to address the OIC's concerns as identified in its Disapproval Letter (as modified by the Conclusions above) would be to invite a consideration that the OIC might have erred in disapproving the Company's filings on July 31. For the OIC to use its discretion in allowing the Company to quickly make modifications now – so that the Company has the opportunity to gain approval and certification to sell its products through the Exchange for 2014 is reasonable and permissible and would both ensure that the Company is in compliance with applicable rules and ensure the OIC's review process was reasonable under these unique circumstances.

ORDER

On the basis of the foregoing Findings of Facts and Conclusions of Law,

IT IS HEREBY ORDERED that the Washington State Insurance Commissioner shall allow the Company a short period of time, which would still accommodate the Exchange in its responsibilities, in which to make new/amended filings which remedy the OIC's concerns expressed in its July 31, 2013 Disapproval Letter (as modified by the Conclusions above);

IT IS FURTHER ORDERED that it is expected that, beginning on the date of entry of this Order, the OIC will provide prompt, reasonable guidance and recommended language to the Company as appropriate to assist the Company in remedying the OIC's concerns expressed in its July 31, 2013 Disapproval Letter (as modified by the Conclusions above), with the common goal of assisting the Company in obtaining the OIC's reasonable review and approval of its filings in time to be certified by the Exchange for sale in 2014;

IT IS FURTHER ORDERED that the OIC shall give prompt review and reasonable approval of the Company's filings provided the Company has addressed the reasons for disapproval set forth in the OIC's July 31, 2013 Disapproval Letter (as modified by the Conclusions above) to the reasonable satisfaction of the OIC and being guided by the above Findings of Fact and Conclusions of Law above;

IT IS FURTHER ORDERED that in light of the unique circumstances of this matter, this proceeding shall remain open until the Company has made new/amended filings, through the Company's and OIC's communications together, and until the OIC has made determination concerning approval of these new/amended filings. At that time, the parties shall notify the undersigned of the disposition of the OIC's review of the Company's amended/new filings;

IT IS FURTHER ORDERED that, also in light of the unique circumstances of this matter, should the parties have questions about the above Conclusions of Law as they relate to the approvability of any new/amended filings, they may contact the Hearings Unit to discuss the issue, which would involve the parties and the undersigned, in an effort to promptly resolve any

outstanding issues which might otherwise delay prompt settlement of any issues concerning new language and/or the OIC's review and reasonable approval thereof.

ENTERED AT TUMWATER, WASHINGTON, this 3rd day of September 2013, pursuant to Title 48 RCW and specifically RCW 48.04 and Title 34 RCW and regulations applicable thereto.

PATRICIA D. PETERSEN
Chief Presiding Officer

Pursuant to RCW 34.05.461(3), the parties are advised that they may seek reconsideration of this order by filing a request for reconsideration under RCW 34.05.470 with the undersigned within 10 days of the date of service (date of mailing) of this order. Further, the parties are advised that, pursuant to RCW 34.05.514 and 34.05.542, this order may be appealed to Superior Court by, within 30 days after date of service (date of mailing) of this order, 1) filing a petition in the Superior Court, at the petitioner's option, for (a) Thurston County or (b) the county of the petitioner's residence or principal place of business; and 2) delivery of a copy of the petition to the Office of the Insurance Commissioner; and 3) depositing copies of the petition upon all other parties of record and the Office of the Attorney General.

Declaration of Mailing

I declare under penalty of perjury under the laws of the State of Washington that on the date listed below, I mailed or caused delivery through normal office mailing custom, a true copy of this document to the following people at their addresses listed above: Jay Fathi, M.D., Katie Rogers, Maren Norton, Esq., Barbara Nay, Esq., Mike Kreidler, James T. Odiorne, John F. Hamje, Esq., Marcia Stickler, Esq., and Annalisa Gellermann, Esq.,

DATED this 3rd day of September, 2013.

KELLY A. CAIRNS

Exhibit B

MIKE KREIDLER
STATE INSURANCE COMMISSIONER

STATE OF WASHINGTON

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

OFFICE OF
INSURANCE COMMISSIONER
HEARINGS UNIT
Fax: (360) 664-2782

Patricia D. Petersen
Chief Presiding Officer
(360) 725-7105

Kelly A. Cairns
Paralegal
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KellyC@oic.wa.gov

BEFORE THE STATE OF WASHINGTON
OFFICE OF INSURANCE COMMISSIONER

In the Matter of	**Docket No. 13-0232**
COORDINATED CARE CORPORATION,	**ORDER ON OIC'S MOTION FOR RECONSIDERATION**
A Health Maintenance Organization.	

TO: Jay Fathi, M.D., President and
Chief Executive Officer
Coordinated Care Corporation
1145 Broadway, Suite 300
Tacoma, WA 98402

Katie Rogers, Vice President of
Compliance and Reg. Affairs
Coordinated Care Corporation
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Stoel Rives LLP
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Portland, OR 97204-1268

COPY TO: Mike Kreidler, Insurance Commissioner
James T. Odiorne, J.D., CPA, Chief Deputy Insurance Commissioner
Molly Nollette, Deputy Commissioner, Rates and Forms Division
AnnaLisa Gellermann, Esq., Deputy Commissioner, Legal Affairs Division
Charles Brown, Senior Staff Attorney, Legal Affairs Division
Andrea Philhower, Staff Attorney, Legal Affairs Division
Office of the Insurance Commissioner
PO Box 40255
Olympia, WA 98504-0255

NATURE OF PROCEEDING

On July 31, 2013, the Insurance Commissioner ("OIC") disapproved Coordinated Care Corporation's ("the Company") July 25, 2013 binder, form and rate filing for its Bronze, Silver and Gold Individual Plan Filings for sales relative to the new Washington State Health Benefits Exchange for 2014. The reasons for the OIC's disapproval (also called "objections") are set forth in the OIC's July 31 Disapproval Letter. On August 13, the Company filed a Demand for Hearing to contest the OIC's disapproval, contending that some of the OIC's objections were not supported by law and/or were inconsistent with prior feedback from the OIC, and also contending that the OIC had not made some of these objections until the deadline date of July 31 which allowed the Company no time to resolve the issues or cure the deficiencies. Because the OIC requested an expedited hearing, after proper notification the hearing was held August 26, 27 and 28 and the undersigned entered her Findings of Facts, Conclusions of Law and Final Order ("Final Order") on September 3. Thereafter, on September 6 the OIC filed its Motion for Reconsideration of the Final Order ("Motion"), asserting that the Final Order *failed to resolve the matter with a decision on the merits ... exceeding administrative judicial authority ...*; *contained conclusions based upon improper admission of evidence of* [the OIC's] *settlement negotiations* with other carriers; *contained errors of law* concerning network adequacy; and *contains the erroneous factual conclusion that OIC improperly refused to communicate with Coordinated Care following the July 31, 2013 denial.* Finally, the OIC implies that the fact that the undersigned considered evidence of the OIC's communications with other carriers after July 31, but refused to communicate with the Company after July 31, might signify that the undersigned might be biased and prejudiced. On September 27 the Company filed its Response opposing the OIC's Motion for Reconsideration, asserting that the Final Order *resolved all matters at issue on the merits, fell well within the scope of the Chief Presiding Officer's authority,* [and] *correctly considered evidence of the OIC's settlement negotiations with other carriers*.... Finally, the Company asserts that *The OIC's accusation that the Chief Presiding Officer is somehow biased or prejudiced* [for considering evidence of the OIC's communications with other carriers but not with the Company] *is completely unfounded* ... [and further that] [t]*he OIC presents no other evidence to suggest that Chief Presiding Officer was not impartial here.*

Therefore, in entering this Order on OIC's Motion for Reconsideration, the undersigned has carefully reviewed the OIC's arguments in its Motion for Reconsideration, Coordinated Care's Response in opposition to the OIC's Motion for Reconsideration, all applicable statutes, regulations and case law cited by the parties, the record of this proceeding and the entire hearing file. Each of the sections of the Final Order, and procedural issues, which the OIC contests in its Motion for Reconsideration is identified and considered in detail in the Analysis section below.

Standard of Review of Motion for Reconsideration. In its Motion for Reconsideration, the Insurance Commissioner does not identify the legal standards that govern motions for reconsideration. However, while Washington's Administrative Procedures Act, at RCW 34.05.470(1), authorizes "a petition for reconsideration, stating the specific grounds upon which relief is requested," it defers to the standard of review established by an agency through

rulemaking. The APA does not indicate the standard of review in the absence of agency rules on the matter, nor has the OIC adopted any such rules of its own. Given this dearth, state rules and standards governing motions for reconsideration should provide guidance here, particularly 1) Washington Civil Rule 59. Additionally, Washington courts often look to the decisions of other courts, even federal courts, for the persuasiveness of their reasoning when trying to decide similar matters, and for that reason it is also helpful to look for guidance to the federal law used by federal courts in Washington hearing civil matters, particularly 2) Fed. R. Civ. P. 59 and Local Rule 7(h).

1) Washington's state courts follow Civil Rule (CR) 59 when considering motions for reconsideration. CR 59(a) provides a list of nine specific grounds for granting motions for reconsideration, briefly: 1) irregularity in the proceedings; 2) misconduct; 3) accident or surprise; 4) newly discovered evidence that the moving party could not with reasonable diligence have discovered and produced at the trial; 5) passion or prejudice; 6) error in assessment of recovery; 7) that there is no evidence or reasonable inference from the evidence to justify the decision or that it is contrary to law; 8) error in law occurring at the trial and objected to at the time by the moving party; or 9) that substantial justice has not been done. Whether one of these grounds is met is "addressed to the sound discretion of the trial court and a reviewing court will not reverse a trial court's ruling absent a showing of manifest abuse of discretion." *Wilcox v. Lexington Eye Institute*, 130 Wn. App. 234, 241, 122 P.3d 729 (2005). Washington state courts also caution that a motion for reconsideration should not be used as a vehicle to get a "second bite at the apple." "CR 59 does not permit a plaintiff to propose new theories of the case that could have been raised before entry of an adverse decision." *Wilcox*, 130 Wn.App. at 241, *citing JDFJ Corp. v. Int'l Raceway, Inc.*, 97 Wn.App. 1, 7, 970 P.2d 343 (1999).

2) Washington federal courts view motions for reconsideration similarly, but the federal court standard more clearly emphasizes that such motions seek an "extraordinary" remedy that should normally be denied. This standard was recently set forth in a June 20, 2012 order by Judge Robert J. Bryan in the civil action *White v. Ability Ins. Co.*, No. 11-5737-RJB (W.D.Wash.):

> Pursuant to Local Rules W.D. Wash CR 7(h)(a), motions for reconsideration are disfavored and will ordinarily be denied unless there is a showing of a) manifest error in the ruling, or b) facts or legal authority which could not have been brought to the attention of the court earlier, through reasonable diligence. The term "manifest error" is "an error that is plain and indisputable, and that amounts to a complete disregard of the controlling law or the credible evidence in the record." Black's Law Dictionary 622 (9th ed. 2009).
>
> Reconsideration is an "extraordinary remedy, to be used sparingly in the interests of finality and conservation of judicial resources." *Kona Enters.*,

> *Inc. v. Estate of Bishop*, 229 F.3d 877, 890 (9th Cir. 2000). "[A] motion for reconsideration should not be granted, absent highly unusual circumstances, unless the district court is presented with newly discovered evidence, committed clear error, or if there is an intervening change in the controlling law." *Marlyn Nutraceuticals, Inc. v. Mucos Pharma GmbH & Co.*, 571 F.3d 873, 880 (9th Cir. 2009). Neither the Local Civil Rules nor the Federal Rule of Civil Procedure which allow for motions for reconsideration is intended to provide litigants with a second bite at the apple. A motion for reconsideration should not be used to ask a court to rethink what the court had already thought through – rightly or wrongly. *Defenders of Wildlife v. Browner*, 909 F.Supp. 1342, 1351 (D.Ariz. 1995). Mere disagreement with a previous order is an insufficient basis for reconsideration, and reconsideration may not be based on evidence and legal arguments that could have been presented at the time of the challenged decision. *Haw. Stevedores, Inc. v. HT & T Co.*, 363 F.Supp.2d 1253, 1269 (D.Haw. 2005). "Whether or not to grant reconsideration is committed to the sound discretion of the court. *Navajo Nation v. Confederated Tribes & Bands of the Yakima Indian Nation*, 331 F.3d 1042, 1046 (9th Cir. 2003).

Burden of Proof and Issue at Hearing. First, the OIC filed a Motion to Determine Burden of Proof at hearing, requesting entry of an order establishing that the Company bears the burden of proof in this case *and that the applicable standard is abuse of discretion or error of law.* The OIC's Motion to Determine Burden of Proof concerned virtually only which party has the burden of proof, and at the outset of the hearing the Company agreed with the OIC that the Company had the burden of proof.[1] Second, at the outset of the hearing the parties agreed that the Company must prove its case by a preponderance of the evidence. Third, at the outset of the hearing the parties also agreed on the issue at hearing. The burden of proof and issue at hearing was stated in Conclusion of Law No. 2 in the Final Order, was not raised by the OIC as an issue in its Motion herein, and remains correctly stated as follows: ***[t]he 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.*** [Emphasis in original.] In its pleadings and at hearing, the parties agreed that this issue requires an evaluation 1) of the Company's July 25, 2013 filing as it was made on July 25; and 2) of the OIC's July 31, 2013 disapproval of this filing as it was made on July 31.

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[1] Although in this Motion herein the OIC has not raised any issue regarding the application of the abuse of discretion or error of law standards, at the end of its Motion to Determine Burden of Proof the OIC simply stated *It is important to keep in mind that this is not a disciplinary case. The OIC does not seek to impose a penalty or revoke a license and no constitutional provisions demand heightened scrutiny of the agency's action. The OIC staff therefore respectfully submits that Coordinated Care Corporation as the party seeking relief ... must demonstrate an abuse of discretion or an error law in order to prevail.* In its Motion the OIC did not assert that in some types of activities the abuse of discretion standard might apply and in other activities the error of law standard might apply.

ANALYSIS-Discussion of Balance of Arguments and Evidence

It is important to note that, as shown in the Final Order, the undersigned's fair and thorough weighing of the Company's and the OICs arguments and evidence relative to some of the significant issues involved in this matter could only lead to a conclusion that the Company simply met its burden of proof at hearing on these issues. Although, as shown below, the OIC misconstrues some parts of the Final Order, at the same time the OIC seems to be contesting every issue which it believes was not decided in its favor and attacking the Final Order and its author for the outcome of this administrative hearing. Had the OIC presented clear, consistent arguments, along with sufficient evidence to support its arguments, then these issues might well have been decided differently in the Final Order. A more specific discussion of this situation is detailed further below, under the issues to which they pertain. However, most generally, the OIC presented three witnesses: 1) The OIC presented its OIC contract analyst Jennifer Kreitler, who reviewed the Company's filing from the beginning and either taught or participated in the OIC's many classes held to train carriers in making filings for their Exchange products which were compliant with the ACA and state laws. While very capable, she lacked legal knowledge and understanding in some areas and was unable to justify portions of her review and disapproval of the Company's filing; she also occasionally changed her testimony and interpretations of rules, and - particularly when questioned by opposing counsel on cross examination - was occasionally shown to have had no reasonable basis for her disapproval of some sections of the Company's filing (e.g. written notice requirement which was one of her bases for disapproval);

2) The OIC did not present Deputy Commissioner Beth Berendt, who (pursuant to Ms. Kreitler's testimony) was Ms. Kreitler's superior and had been in charge of the Company's filing from the beginning; who along with Ms. Kreitler met with the Company; who apparently made the bulk of the decisions regarding approval or disapproval of sections of the filing; and who was also the sole individual with whom the Company was allowed to communicate in the later stages of the process and up until July 31. Instead, the OIC presented Ms. Berendt's very recent replacement, Deputy Commissioner Molly Nollette, who testified she was not yet familiar with Affordable Care Act ("ACA") and had not been employed in her current position during most of the time when the OIC was reviewing the Company's filing and making decisions regarding approval or disapproval of various sections; and

3) Finally, the OIC also did not present its actuary, Lichiou Lee, who (pursuant to Kreitler's and Jetha's testimony) had reviewed and made decisions on the Company's filing throughout the process. Instead, the OIC presented actuary Shirazali Jetha, who testified he had not been part of the OIC's review of the Company's filing and even at the time of his testimony he stated that he had not even reviewed the entire filing.

In contrast, the Company also presented three witnesses:

1) The Company presented Sara Ross, its Manager of New Products and Programs Operations, who had worked on the filing since its inception, had attended all or most of the OIC's training sessions, and had communicated in person and otherwise with the OIC throughout the entire filing process;

2) The Company also presented its actuary, Jason Nowakawski, who had worked on and indeed drafted most of all of the filing since its inception; and

3) The Company also presented Jay Fathi, M.D., who has substantial knowledge and years of experience in the area of access to and delivery of medical care, and who had been involved in and communicated with the OIC since the beginning (his further credentials are detailed below).

OIC's Arguments. The OIC presents four arguments in support of its Motion for Reconsideration. While some of the OIC's arguments are repeated in its arguments, they are each identified and addressed below under at least one of the OIC's arguments:

I. **(OIC's Argument No. 3 in support of its Motion for Reconsideration): The network adequacy issue. The OIC argues that the Final Order contains errors of law that effectively force the OIC to permit Coordinated Care to enter the Exchange with an insufficient network [Pediatric Specialty Hospitals and Level I Burn Units], contrary to the laws applicable to health maintenance organizations.**

In response, the network adequacy issue is perhaps the most significant issue in this proceeding. This issue questions whether the Company is required to include Pediatric Specialty Hospitals and Level I Burn Units in its network.[2]

A. **Network Adequacy: inclusion of Pediatric Specialty Hospital(s) and Level I Burn Unit(s).** As referenced in Analysis above, this issue involved a clear imbalance of arguments and evidence presented by the parties. The Company met its burden of proof to support its position. Had the OIC presented clearer and more focused arguments, and strong, adequate and consistent evidence to support its current position that Pediatric Specialty Hospitals and Level I Burn Units must be included in the Company's network then this issue may well have been decided differently. All efforts would have been made to allow and consider any evidence the OIC presented on this issue - from its qualified staff, other professionals, interested providers and parties - along with the Company's evidence.

Some evidentiary problems at hearing are summarized below:

(1) The OIC testified that its remaining network adequacy issues were that

[2] While the OIC does not identify Pediatric Specialty Hospitals and Level I Burn Units in its Motion herein, and although as detailed below the OIC presented conflicting testimony on this requirement, these were the only two types of providers identified by the OIC (at least at some points in the hearing) as still needing to be included in the Company's network. The OIC had originally also included massage therapists as needing to be included but by the end of the hearing, based upon evidence from the Company that massage therapists were already included, the OIC dropped its objection that no massage therapists were included in the Company's network. In addition, the OIC asserts that the Final Order "effectively forced" or "required" or "directed" the OIC to approve the Company's filing and/or to settle the issues herein with the Company; although this assertion is made in several sections of the OIC's Motion, it is addressed in section II.A. below.

Pediatric Specialty Hospitals and Level I Burn Units were not included in the Company's network [testimony of Kreitler]. Relative to this issue, the Company presented clear argument and evidence, correctly, that neither RCW 48.46.030 nor WAC 284-43-200 specifically require it to include Pediatric Specialty Hospitals and Level I Burn Units in its network, but that instead WAC 284-43-200 requires that *A health carrier shall maintain each plan network in a manner that is sufficient in numbers and types of providers and facilities to assure that all health plan services to covered persons will be accessible without unreasonable delay.* The Company then presented clear evidence, uncontroverted by the OIC, to show that it can provide 99% of covered pediatric and burn services through its network providers which are non-Pediatric Specialty Hospitals and non-Level I Burn Units and that therefore the Company is in compliance with WAC 284-43-200. More specifically, the Company presented credible argument and evidence that in its network it has 8,000 providers; has at least 30 hospitals including Shriner's Hospital and Sacred Heart Medical Center in Spokane and Mary Bridge Children's Hospital in Tacoma; has all of the Providence network of providers and apparently all of the Swedish network of providers (accordingly to Dr. Faithi's testimony Providence and Swedish have merged and have the same negotiating committee); that it went to talk to - and contracted with - all willing providers in rural counties; and that its network covers 14 counties. This testimony was primarily from Jay Faithi, M.D., a family physician who worked for 14 years in community care clinics for Medicaid patients and the uninsured, then has worked for Swedish health services as its Director of Primary Care and currently remains there as an instructor in Swedish's family practice program. In contrast, the OIC did not object to this testimony, and presented no testimony of its own to contradict or raise a reasonable question about either the testimony or the individual physician presenting it (Dr. Faithi is CEO of the Company). Neither did the OIC present clear evidence of its own to controvert the Company's testimony or to support its current position that the Company cannot *maintain each plan network in a manner that is sufficient in numbers and types of providers and facilities to assure that all health plan services to covered persons will be accessible without unreasonable delay* even with its current network, or that the Company cannot comply with this rule unless it included Pediatric Specialty Hospital(s) and Level I Burn Unit(s) in its network. Indeed, the OIC even changed its own position on whether these two types of providers were or were not required to be included in the Company's network. Indeed, e.g., as discussed below, the OIC could not identify a single service that the Company's current network could not provide, except for NICU services which the Company had already identified in its filing.

(2) The OIC's position on whether RCW 48.46.030 or WAC 284-43-200 do or do not require that Pediatric Specialty Hospital(s) and Level I Burn Unit(s) be included in the Company's network was inconsistent. First, in its Hearing Brief, the OIC argued that RCW 48.46.030 and WAC 284-43-200 do require the Company to include Pediatric Specialty Hospitals and Level I Burn Units in its network [Hearing Brief, pgs. 9-12]. Second, at hearing the OIC first testified that RCW 48.46.030 and WAC 284-43-200 do require the Company to include Pediatric Specialty Hospitals and Level I Burn Units in

its network [Testimony of Kreitler]. Third, on cross examination the OIC agreed, correctly, that these rules do not specifically require the Company to include Pediatric Specialty Hospitals and Level I Burn Units in its network [Testimony of Kreitler] but that WAC 284-43-200(1) requires that the Company *maintain each plan network in a manner that is sufficient in numbers and types of providers and facilities to assure all health plan services to covered persons will be accessible without unreasonable delay.* The OIC's witness [Kreitler] agreed that there is no statutory requirement for a pediatric specialty hospital to be included in the Company's network, agreed that it does not require that the services be provided in a hospital at all - not to mention a Pediatric Specialty Hospital. Importantly as well, on cross examination the OIC's witness could not identify any burn service or any pediatric services which would be available at a Pediatric Specialty Hospital that the Company's network (including Providence) could not also provide except for NICU Level 4 which the Company had already identified in its filing. [E.g., testimony of Kreitler (JK) on cross examination: Company: *That* [NICU Level 4] *is the only service they* [the Company] *have identified as an example of potentially one that wouldn't be available in the network?* JK: *Yes.* CC: *You don't know of any others?* JK: *No.*]

(3) The Company's clear, uncontroverted evidence showed that Dr. Faithi specifically asked the OIC whether Seattle Children's Hospital (a Pediatric Specialty Hospital) was required to be included in its network, and the OIC responded that the Company was not required to include Seattle Children's Hospital in its network. The Company also presented evidence that if the OIC had told it [the Company] that Children's was required to be in its network then it would have done so. [Dr. Faithi testified *I think globally, from our standpoint, there seemed to be a lack of clarity. There are very prescriptive network requirements in, for example, Medicaid, and those seem to be somewhat lacking in this realm. And so there was some ambiguity, again I think I already said in our testimony, if we were told "You are required ... to contract with Seattle Children's" then that would've been very clear and we would've done it. We would've made it happen. I asked that question and the answer was No.*] The OIC neither objected to admission of this evidence nor presented evidence of its own to controvert or even question this evidence.

(4) Although the OIC did not identify lack of Pediatric Specialty Hospitals, Level I Burn Units or any other providers or facilities in the Company's network as a reason for disapproval in its July 31 Disapproval Letter, it does state that under RCW 48.46.030 and WAC 284-43-200 the Company *is required to demonstrate it has 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.* The OIC further advises that it had *reviewed Coordinated Care's Provider Network Form A, Access Plan, and GeoNetwork report, and determined the network does not have sufficient contracted providers and facilities in place to support the services set forth in the product.* As above, the OIC did not specify what providers were still required

to be included in the Company's network, at hearing the OIC advised that the remaining providers at issue herein were Pediatric Specialty Hospitals and Level 1 Burn Units although as above, the OIC's statements regarding this requirement, with unsupported evidence, were not sufficient to controvert the Company's argument and evidence presented.

(5) Finally, even if it were appropriate to present new evidence here on reconsideration, the OIC in this Motion still fails to argue - and certainly fails to provide evidence – that Pediatric Specialty Hospitals and Level I Burn Units must be included in the Company's network (indeed, in its Motion the OIC does not even mention Pediatric Specialty Hospitals and Level I Burn Units or otherwise identify just what services must be included in the Company's network). As stated above, had the OIC presented clear argument and evidence to support its current position that Pediatric Specialty Hospitals and Level I Burn Units must be included then this issue may well have been decided differently. All efforts would have been made to allow and consider any evidence the OIC presented on this issue - from its qualified staff, other professionals, interested providers and parties - along with the Company's evidence.

B. **Network Adequacy: can the Company's compliance with network adequacy standards for Medicaid participation be used to demonstrate network sufficiency required by WAC 284-43-200(1) for Exchange products?** In its Motion on this issue, as discussed above in Analysis – Discussion of Balance of Evidence, the OIC seems to fail to recognize the primary importance of presentation of clear and persuasive argument and evidence concerning the proper interpretation and application of WAC 284-43-200(1) and (2); instead, the OIC simply argues that the Final Order misconstrues WAC 284-43-200(2). WAC 284-43-200 provides:

> *(1) A health carrier shall maintain each plan network in a manner that is sufficient in numbers and types of providers and facilities to assure that all health plan services to covered persons will be accessible without unreasonable delay. Each covered person shall have adequate choice among each type of health care provider, including those types of providers who must be included in the network under WAC 284-43-205. ... Each carrier shall ensure that its networks will meet these requirements by the end of the first year of initial operation of the network and at all times thereafter.*
>
> *(2) Sufficiency and adequacy of choice may be established by the carrier with reference to any reasonable criteria used by the carrier, including but not limited to: Provider-covered person ratios by specialty, primary care provider-covered person ratios, geographic accessibility, waiting times for appointments with participating providers, hours of operation, and the volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care. Evidence of carrier compliance with network adequacy standards that are substantially similar to those standards established by state agency health care purchasers (e.g., the state health care*

> *authority and the department of social and health services) and by private managed care accreditation organizations may be used to demonstrate sufficiency.*
>
> *(3) 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. ...* [Emphases added.]

In it Motion, without identifying any section of the Final Order in support of its argument, the OIC incorrectly assumes that the Final Order *erroneously conflates* [the Company's] *... Medicaid network as an 'adequate network' for commercial products ....* [and] argues that *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(2), 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* [sic] *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.* The OIC goes on to argue that this is particularly important for Medicaid carriers whose plans do not have to offer all of the ten essential health benefits required under the ACA.

In response, first, the OIC has misread the Final Order. Although the OIC fails to point to any section of the Final Order which states what the OIC suggests, clearly WAC 284-43-200(2) does not conclud[e] *that a Medicaid network is automatically adequate for a commercial policy.* Nor does the Final Order *provide its statutory or legal basis for the conclusion* because the Final Order no where makes this conclusion. Second, of course the differences between Medicaid networks and ACA networks is an important distinction. The OIC fails to point to any portion of the Final Order which might support its argument here. At any rate, in consideration of the issues herein and entry of the Final Order, little weight was given to the fact that the Company had its network approved by the Washington State Health Care Authority for use in the Medicaid market, although certainly WAC 284-43-200(2) does provide that *sufficiency ... may be established by the carrier with reference to any reasonable criteria used by the carrier, including but not limited to ... the volume of ... specialty services available to serve the needs of covered persons requiring ... specialty care. Evidence of carrier compliance with network adequacy standards that are substantially similar to those*

standards established by state agency health care purchasers (e.g., the state health care authority and the department of social and health services) ... may be used to demonstrate sufficiency. It is interesting to note as well, however, that at hearing, the OIC seems to have contradicted its position here, in testifying that *standards for network adequacy are found in WAC 284-43-200*, and that *one of the ways to establish network adequacy is evidence of carrier compliance to network adequacy standards that are essentially similar to those standards established by state agency health care purchasers ... state health care authority.* The OIC further testified that this was an *available standard* and [a]n *acceptable standard* which carriers can use to establish adequacy. [Testimony of Kreitler.]

C. **Network Adequacy: can the Company use single case contracts for pediatric specialty and level 4 burn services?** Once again without identifying any specific section of the Final Order to which it objects, and without identifying the providers at issue as Pediatric Specialty Hospitals and Level I Burn Units, in its Motion the OIC asserts that the second error the Final Order makes regarding network adequacy concerns the Company's failure to contract with Pediatric Specialty Hospitals and Level I Burn Units and to instead use single case contracts in limited occasions.[3] Citing RCW 48.46.030(1), the OIC argues that a *fundamental requirement for HMOs* is that *all covered services must be provided either directly* [e.g. Group Health] *or through contracted* [network] *providers.*

In response, first, in the hearing and now in this Motion, the OIC fails to present a convincing argument that RCW 48.46.030(1) actually does prohibit HMOs from utilizing single case contracts. Second, the OIC ignores WAC 284-43-200(3), cited above, the regulation which implements RCW 48.46.030(1) written by and adopted by the OIC, which actually does expressly allow carriers to utilize out-of-network providers as long as the consumer is not put in a worse position. For this reason, once again, the undersigned considered the Company's argument and evidence against the OIC's argument and evidence in considering and entering the Final Order: in its Prehearing Brief the Company argued [Prehearing Brief at pg. 9-10], and at hearing presented evidence [Testimony of Fathi], that it can provide pediatric services, including hospital services, through its four children's specialty service providers and hospitals and argued that these providers can provide 99% of the services provided by Seattle Children's Hospital. [Company's Prehearing Brief at pg. 12-11; Testimony of Fathi.] While the Company acknowledged there may be rare, unique types of care that are not provided by its network facilities, it would provide those services through use of single case contracts, which it argued persuasively were allowed under WAC 284-43-200. Indeed, the Company raised evidence of a Regence contract that specifically handles provision of pediatric specialty services through single case contracts which was apparently approved by the OIC and currently on the market. Finally,

[3] While the OIC does not identify Pediatric Specialty Hospitals and Level I Burn Units in its Motion herein, these were the only types of providers identified by the OIC as still needing to be included in the Company's network. The OIC had originally also included massage therapists as needing to be included but by the end of the hearing, based upon evidence from the Company that massage therapists were already included, the OIC dropped its objection that no massage therapists were included in the Company's network.

the Company went on to argue in its Prehearing Brief and in testimony at hearing that it believed the OIC's real complaint appears to be that it did not include Seattle Children's Hospital (the renowned Pediatric Specialty Hospital affiliated with University of Washington) in its network. In its Prehearing Brief the Company further asserted, and at hearing presented uncontroverted testimony, that in July 2013 the OIC expressly told the Company that it was not required to contract with Children's to have an adequate network [Testimony of Fathi] and that it would have contracted with Children's if the OIC had advised it that it was required to do so. [Testimony of Fathi.]

In contrast, at hearing the OIC did not clearly raise the distinction it now might be making in this Motion, i.e. that it is essential services, rather than other services, that cannot be provided through single case contracts. However, this was an argument that could have been made at hearing and was not. Further, at hearing, as above, the OIC was unable to name one type of pediatric specialty service or burn service that could not be provided by the Company's current network providers (except for Level 4 NICU, which the Company had already identified in its filing).

Therefore, consistent with its obligation to meet its burden of proof, from the outset of the hearing in its Prehearing Brief through the hearing, the Company presented argument and evidence to support its position that its network was sufficient to provide virtually all required services by its non-Pediatric Specialty Hospital and non-Level I Burn Unit network providers. [Testimony of Fathi.] The OIC did not object to the Company's argument or evidence presented, and presented virtually no evidence of its own to contradict the Company's argument and evidence. Indeed, the OIC's argument and testimony focused on whether the Company's network providers were in adequate locations, not the fact that the Company's network did not include Pediatric Specialty Hospitals or Level I Burn Units (consistent with that part of the OIC's testimony which changed to state that the rules do not specifically require inclusion of these providers in the Company's network). The issue of whether or not the Company is prohibited from utilizing single case contracts in limited situations, and apparently most particularly regarding provision of some types of pediatric specialty services and level 4 burn services, is simply another situation where, after the undersigned's fair and thorough weighing of the Company's and the OICs arguments and evidence, the undersigned could only reach the conclusion that the Company met its burden of proof at hearing on this issue. Once again, as stated above, had the OIC presented clear argument and evidence to support its current position that Pediatric Specialty Hospitals and Level I Burn Units must be included then this issue may well have been decided differently. All efforts would have been made to allow and consider any evidence the OIC presented on this issue - from its qualified staff, other professionals, interested providers and parties - along with the Company's evidence.

II. (OIC Argument No. 1 in support of its Motion for Reconsideration): The OIC argues that the Final Order failed to resolve the matter with a decision on the merits, and instead improperly directed settlement between the OIC and Coordinated Care. In this, the OIC argues, the Final Order exceeds administrative judicial authority, and is unsupported by law.

A. The OIC asserts in several sections of its Motion that the Final Order *improperly directed settlement* and *ordered* the OIC to approve this filing and *required settlement* and therefore exceeded administrative judicial authority.

In response, as shown in the Final Order, had the OIC continued to disapprove this filing after entry of the Final Order, there were no consequences. At the outset of the hearing, the OIC proposed, and the Company agreed, and the OIC did not challenge in this Motion, that the issue in the proceeding was *whether, on July 31, 2013 the OIC erred in disapproving Coordinated Care Corporation's June 25, 2013 filings*. As specifically stated in the Final Order but ignored by the OIC in its Motion herein, the parties agreed that the undersigned must strictly consider this issue as it existed on July 31, i.e. the undersigned must consider 1) the wording of the Company's filings, as they existed on July 31; and 2) the OIC's reasons, as they existed on July 31, for disapproval of these filings. In other words, the OIC's post-July 31 reasons for its July 31 disapproval were not at issue in the proceeding and could have simply been excluded by the undersigned in deciding whether the OIC properly disapproved this filing on July 31.

Instead of simply excluding all of the OIC's post-July 31 objections, however, as is shown by a reading of the Final Order and as argued by the Company in its Response to OIC's Motion herein, **the instances where the undersigned recognized the OIC's concerns and determined that the OIC should at least allow the Company to address these concerns were limited to those new (post-July 31) concerns which at hearing the OIC was attempting to apply retroactively to justify its July 31 disapproval. As above, while the OIC's post-July 31 reasons could have been excluded entirely, the undersigned recognized the OIC's post-July 31 reasons because:**

> (1) Reliance on only the OIC's reasons which were stated in its July 31, 2013 Disapproval Letter would have a distinctly increased likelihood of resulting in a Final Order which determined that the OIC had erred in disapproving the Company's July 31 filing (which apparently is why the OIC chose post-July 31 to present new or different reasons at hearing). This was done particularly in light of the fact that, pursuant to the Company's testimony at hearing and the OIC's acknowledgement of its process at that time, the OIC had refused to communicate with the Company since July 31 when the evidence showed that it had communicated with other carriers whose filings had been disapproved on July 31; and the Company had presented substantial evidence that it was ready and willing to communicate with the OIC and to change its July 31 filing to cure any of the OIC's remaining pre-July 31 or post-July 31 concerns if it knew what these

remaining concerns were (it having also been found that some of the OIC's July 31 objections were so unclear as to render the Company unable to know what they were and thus how to address them). Even where these objections were clear, some were shown through direct and cross examination to be requirements which were not even supported by law. For example, while on July 31 one of the OIC's reasons for disapproval was that the Company's requirement of written notice to add covered individuals was its provision was "overly restrictive" when clarified by the OIC witness the OIC's objection was actually shown to not be supported by statute at all. [Conclusion of Law No. 11; *see also* Testimony of Kreitler.]

(2) The undersigned recognized the OIC's post-July 31 reasons in an effort to promote settlement as encouraged by the Administrative Procedure Act, Title 34 RCW, particularly in light of the issues discussed in 1) above. For example, on July 31 some of the OIC's reasons for disapproval were that specific provisions in the Company's filing were "too restrictive" or in conflict with specific laws, but post-July 31 (i.e. at hearing) the OIC changed these reasons to argue instead that these provisions were 'confusing and misleading.' [*See, e.g.,* OIC Objections 7, 9, 12 set forth in OIC's July 31 Disapproval Letter; after July 31 the OIC abandoned these July 31 bases for disapproval by asserting new bases in their stead.] The OIC asserted new (post-July 31) reasons for a number of its July 31 objections as well. For these reasons, where the undersigned found that the OIC's post-July 31 reasons for disapproval had merit, the undersigned required the OIC to promptly review and/or suggest amended language that would address its concern.

Therefore, contrary to the OIC's assertions, as discussed in section A. above and as shown by a reading of the Final Order, specific determinations were made therein as to the validity of the OIC's July 31 reasons for disapproval which the OIC did not change or replace post-July 31 at hearing. Rather than simply being excluded altogether as could have been done, the undersigned handled the question of the validity of the OIC's new post-July 31 reasons in an effort to promote settlement as encouraged by as discussed in detail in A. above.

B. It appears the OIC argues in its Motion that the undersigned had authority only to decide 1) whether every section of the Company's filing was consistent with law or not; and 2) if the undersigned concluded that even one section of these filings was noncompliant with any applicable federal or state statutes or regulations on July 31 then the undersigned must uphold the OIC's disapproval of these filings, because even the OIC itself had no authority to approve a plan which contained even one section which is noncompliant with any applicable federal or state statutes or regulations on July 31. In its Motion herein, the OIC argues that because the undersigned did find there were some violations of those applicable rules (presumably based on the OIC's reasons post-July 31 as well as on July 31) then the undersigned should have upheld the OIC's disapproval, but that instead she *improperly directed settlement between the OIC and*

Coordinated Care [of those sections which she found to be noncompliant] ... and thereby *exceeds administrative judicial authority....*

In response, the OIC fails to recognize that at the outset of the hearing, the parties agreed, and Conclusion of Law No. 3 reflected, that the issue in this proceeding is whether on July 31, 2013 the OIC erred in disapproving the Company's July 25, 2013 filings. [*See also* Burden of Proof and Issue at Hearing section above.] Further, the OIC did not raise Conclusion of Law No. 3 as an issue in its Motion herein. As further stated in the Final Order at Conclusion of Law No. 3, which , again, the OIC did not raise as an issue in this Motion, [t]*his* [issue] *contemplates not only whether all sections of the filings comply with all applicable statues and regulations ... but also whether the OIC's process of review was reasonable. ... a determination of the central issue herein must of necessity include not only whether the filings were in compliance with applicable rules but also must include some basic consideration of the review process which the agency conducted; ... this is particularly true where, as here, the Company raises significant issues regarding the review process and claims that process unreasonably restricted its opportunity to have its filings approved. Indeed, while the OIC argues that the only issue is whether the Company's filings are fully compliant with all applicable rules, at the same time the OIC spent far more time – literally hours – presenting written documents and oral testimony solely regarding its process of reviewing these Exchange filings, both in general and with regard to this Company's filings. Therefore, the OIC itself seems to contemplate that its review process is relevant to determination of the central issue herein.* [Emphasis in original.]

D. The OIC then states that *[t]he 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 Exchanges ... Final Order at pg. 3, paragraph 3.* This statement is entirely without merit: nowhere does the Final Order "*compel OIC to re-write Coordinated Care's filings for it.*" The OIC then urges the undersigned to "*reconfigure the Final Order, making it abundantly clear that the specific situation involved in this particular review of the Company's filings is unique.* This is not necessary, since much time and language is included in the Final Order to reflect the uniqueness of this situation, e.g., *the specific situation involved in this particular review of the company's filings is unique.* [Final Order, at 21.] Finally, although this is clear, the OIC need not be concerned that there will be *perils presented by reference to the Final Order as precedent* because, as the Company points out, decisions in these proceedings are not precedential. The OIC then predicts that *ordering the OIC to settle its disputes concerning this Company's filings ... 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* and further that *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 ... 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.* Once again, the OIC is encouraged to read the

Final Order carefully, to recognize its applicability to this unique situation, and to recognize that it is, in fact, *reading too much into the Final Order* (see below).

E. Finally, the OIC questions whether the *OIC may be reading too much into the Final Order*. The OIC is correct: the OIC is reading too much into the Final Order. The Final Order speaks for itself.

III. (OIC's Argument No. 2 in support of its Motion for Reconsideration): The OIC argues that the Final Order's conclusions rest upon improper admission of evidence of the OIC's settlement negotiations with other carriers.

Again citing no portion of either the Final Order or the proceedings to support its argument No. 2, the OIC argues generally that the Final Order's "challenged directives" 1) rely on factual errors that 2) are supported solely by evidence of the OIC's settlement negotiations with other carriers *which was introduced by the Hearing Officer, not by either party*, 3) which should have been barred by ER 408, and 4) which are not supported by the record. The OIC does not articulate just what "challenged directives" it is referring to, and what "factual errors" it is referring to so it can only be speculated what "factual errors" they were that were "not supported by the record." However, the matter of "introduction of evidence by the Hearing Officer," must be addressed, and then the meaning of the balance of this argument can only be guessed at and addressed. [OIC's Motion at pg. 8.]

In response, 1) Very definitively, *no* evidence at all was introduced by the undersigned in this proceeding. Insofar as is relevant here, all evidence of the OIC's negotiations with other carriers was introduced by the Company and in statements made by OIC counsel. Whereas the OIC argues that the undersigned introduced evidence, this is clearly not the case; beginning even prior to the hearing in the Company's brief, the Company has asserted that the OIC was treating it unfairly in many ways. The Company carried this issue throughout the hearing, and continued to support its assertions of unfair treatment, including its own testimony that the OIC had approved other carriers' filings after July 31 which it had disapproved on July 31 when it had refused to even talk to the Company after it had disapproved the Company's July 31 filing. For example, evidence presented by the Company on Day 3: Dr. Fathi: *I was told by Ms. Gellermann we weren't allowed to have conversations since the appeal* [i.e. the Demand for Hearing was filed], *We have lots of ... every day. We've modified things since we got the rejection. We were told that we're not allowed to discuss this. ... I and the company are results and solutions oriented and so I want to take your through how that played out. Molly called me with the news on August 1 and within two days after consulting with outside counsel, our own internal persons, we decided to file the appeal. At the same time we pursued setting up a meeting with the commissioner. Two or three days later, Ms. Gellermann called me and said I've called you to say I understand you have filed an appeal and I need to let you know that we cannot talk to you, cannot talk to you about the appeal. As you may recall a few days later there was a window of a mythological extension of a few days, on a Wednesday in the morning there*

was a note that said you have until Friday to refile things for plans that have been disapproved. For about 7 or 8 hours, during that time I left messages and sent emails to saying I'd like to withdraw our appeal as of right now because we want to make this work, we want to work with you [the OIC], *we're willing to make any of the change that you* [OIC] *require. Before she could even respond to that we got another email that said we* [OIC] *changed our minds there is no extension. What's done is done. Officially it's closed. So at that point we made sure we refiled the appeal. Throughout the last few weeks I would've loved nothing more to work with Ms. Kreitler and ... to ... I have found out from the public website that all of the other plans that have been disapproved* [on July 31] *have already refiled* [with the OIC]. *I have no idea whether they have been in contact with the OIC or not. We are completely ready to refile ... and have been actually.* [Emphasis added.]

On the subject of whether or not the OIC was negotiating with other carriers and not the Company after July 31, in addition to the testimony of the Company discussed above, while not under oath, AnnaLisa Gellermann, counsel for the OIC, stated: Ms. Gellerman: *TheCommissioner is taking the position that for those companies that did not request a hearing we would not accept any new filings, ... For those that requested a hearing, the commissioner has authorized some small changes ... (inaudible)... Not with this company. ...If there is a meaningful opportunity – how far away from* [approval the filing is]*... If you've been disapproved, you're done. July 31, everything is done. If you requested a hearing, and you are in the process of a hearing, we are using the potential of settlement negotiations to determine if there is anything that can be done for those companies that in the opinion of the OIC are very close to approval.* [Unsworn statement of Gellerman, counsel for OIC, presented during Day 3 of hearing at 5:00 p.m..]

Therefore, clearly evidence regarding whether the OIC was negotiating with other carriers after July 31 was presented by the Company and in a statement from OIC counsel, and most definitely not the undersigned. Further, this evidence is specifically identified in Finding No. 20 as the basis for finding that the OIC was negotiating with other carriers: *...the Company testified at hearing, and it was acknowledged by OIC counsel, and is therefore here found, that the OIC has in fact entertained communications, settlement negotiations and new/amended filings with other similarly situated carriers whose filings it disapproved on July 31 even though it has refused to allow any communications with Coordinated Care. [Testimony of Fathi.]* [Finding of Fact No. 20.]

2) Second, the OIC does not identify what "factual errors" it is referring to, it is not possible to review and consider this portion of the OIC's argument. To the extent there was evidence of settlement negotiations with other carriers presented by the Company and to some extent the OIC, this evidence had no bearing on whether the OIC's July 31 objections to the Company's July 25 filing were reasonable. To the extent this evidence were relevant at all it would be considered relative to whether the OIC's erred in its process of review and disapproval of the Company's July 25 filing [See Conclusion of Law No. 3] but in fact this evidence was given no weight and did not affect the Final Order in any way.

3) Third, assuming that ER 408 applies to this proceeding by virtue of RCW 34.05.452(2) (which requires a presiding officer to refer to the Washington Rules of Evidence as guidelines for evidentiary rulings): in this Motion the OIC recognizes that ER 408 does permit evidence of settlement negotiations for limited purposes such as to prove bias, and for other reasons, but the OIC then incorrectly asserts that there was no claim of bias in this case. Contrary to the OIC's argument here, from even before commencement of the hearing the Company asserted that the OIC was treating it unfairly (i.e. in a biased manner) in the approval process and thereby made bias a significant issue in this case. [E.g., Prehearing Brief, pgs. 1-4; Testimony of Dr. Faithi; Testimony of Sarah Ross.] Even the OIC entertained bias as an issue in this case, presenting hours of evidence of how it had spent extra time and effort helping this particular Company in comparison to others. The issue regarding whether the OIC was treating the Company was being treated unfairly was also recognized in the Final Order at Finding of Fact No. 20, which states: *Coordinated Care argues that it is being treated unfairly in comparison with other carriers. [Coordinated Care Prehearing Brief; Testimony of Faithi.*]

More specifically, evidence that bias was a significant issue in this case were – whether or not they were proven at hearing - the Company specifically argued that the OIC was treating it unfairly in comparison to other carriers seeking to have their products approved for the Exchange [Company's Prehearing Brief, pgs. 2-4]: beginning in its Prehearing Brief filed prior to commencement of the hearing, Company asserted that the OIC had indicated it would rather deal with only commercial carriers for this year's Exchange and with Medicaid carriers (such as the Company) next year; that the OIC changed its cooperative attitude with the Company when the Company decided to build its own network and began rejecting submissions for overly technical reasons; that the OIC did not conduct a full analysis of the Company's submission until July 2013 despite the fact that it had a complete product to review beginning with the Company's June 2013 filing; that the OIC's approach to the Company differed from the OIC's treatment of the commercial carriers e.g. the OIC issued numerous objection letters to other carriers, e.g. the Company asserted that the OIC sent objection letters to Group Health in May, June, and July, and gave those carriers opportunities to correct their errors in order to assist them in submitting an acceptable plan for approval, yet the OIC sent only one set of objections to the Company in July many of which were vague or unclear [Ex. 53, OIC July 22 Objection Letter to form filing; Ex. 55, OIC July 17 objection letter to binder; Ex. 57, OIC objection letter to rate filing]; that throughout the process the OIC gave the Comp[any conflicting instructions, e.g. re whether or not Children's Hospital must be included in its network; that other advice was vague or unclear and yet later on the Company was instructed not to contact Kreitler to ask questions, which made it more difficult and expensive for the Company to try to determine what the OIC's remaining concerns were and yet despite its efforts on July 31 the OIC disapproved the Company's entire filing and determined not only that it could not refile but that the OIC could not communicate with the Company at all, which left the Company no time to address any remaining concerns it might not have understood correctly (not having access to the OIC for some time); and after July 31 the OIC refused to communicate with the Company.

4) The OIC argues that the record does not support any findings that the OIC was

communicating with other carriers; presumably the OIC means findings that the OIC was communicating with other carriers after July 31, 2013. However, clearly the record supports such a finding. See Section 1) above concerning the Company's and the OIC's own statements that the OIC was communicating with other carriers after July 31, 2013. As stated above, however, the evidence presented by the Company and statements of the OIC that the OIC was communicating with other carriers after July 31 is not relevant to the issue in this proceeding regarding whether or not the Company's filings as written were in compliance with the ACA and state rules; while the Company's evidence and the OIC's statements might be relevant to whether the OIC erred in its review and disapproval which as above and as stated in Conclusion of Law No. 3 included some consideration of the review process, this evidence was given no weight and did not affect the Final Order in any way.

For the above four reasons, the OIC's argument is without merit.

IV. (OIC's Argument No. 4 in support of its Motion for Reconsideration): The OIC argues that 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.

This argument is duplicative of Argument No. 2 in the OIC's Motion, which is addressed in Section III above. However, toward the end of its Motion, the OIC lodges a host of assertions related to this argument. More specifically, the OIC states 1) that RCW 34.05.461 provides that a "*presiding officer shall not base a finding exclusively on inadmissible evidence unless the presiding officer determines that doing so would not unduly abridge the parties' opportunities to confront witnesses and rebut evidence and the basis for this determination shall appear in the order.*" Then, the OIC goes on to state, incorrectly, that "*the evidence presented by the Hearing Officer about settlement negotiations with other parties ... was not submitted by either party, but by the Hearing Officer herself....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....*" In response, contrary to the OIC's assertions, the Company was very clearly aware that the OIC was in communication with other carriers when it refused to communicate with this company, and testified to its knowledge at hearing. [Testimony of Fathi; Testimony of Ross.]

The OIC further argues that the undersigned's decision "*to not only consider, but inject, evidence of the OIC's settlement discussions in other proceedings as evidence 'calls the Hearing Officer's impartiality into question.'*" The OIC then concludes that by presenting the evidence of the OIC's settlement negotiations, the Hearing Officer essentially made herself a material witness concerning disputed factual allegations and in doing so "*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.*" The OIC even goes on to argue that 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, citing cases irrelevant to the situation at hand. The OIC then concludes this litany of rules which are either not applicable, or not based on fact, by arguing that "*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 ..., the Final Order should be reconsidered, omitting this improperly admitted information and the directives based upon it.*" In response, contrary to the OIC's assertions, once again, as discussed above, the Company argued in its Prehearing Brief that the OIC treated it unfairly in many ways specified therein, and at hearing presented evidence of these activities (whether or not they were found to have occurred), including the OIC's refusal to communicate with the Company post-July 31 and presented further evidence that after July 31 the OIC approved the plans of other carriers like the Company who had filed Demands for Hearing (and perhaps others) whose filings it had disapproved on July 31. [Testimony of Fathi; Statement of OIC counsel.]

In further response to the OIC's fourth set of arguments, as above, the parties agreed that the issue in this proceeding was *whether the OIC erred, on July 31, in disapproving the Company's July 25 filing.* From before the hearing in its Prehearing Brief, the Company argued that the OIC was treating it unfairly in the approval process, and at hearing presented evidence that the OIC was negotiating with other carriers. Bias was raised by the Company from the outset and was a significant issue in this proceeding. Therefore bias should have been, and was, considered by the undersigned in entering the Final Order; therefore even assuming ER 408 applies, ER 408 allows the presiding officer to consider evidence of settlement negotiations to show bias. Further, the Final Order certainly did not *rely exclusively on inadmissible evidence.* E.g., contrary to the OIC's assertions, the Company certainly knew, and testified to, the fact that the OIC was communicating after July 31 with other similarly situated carriers it had disapproved on July 31: Dr. Fathi testified he had seen on the internet that the OIC had approved other carriers' plans which he knew had been disapproved on July 31. [Testimony of Fathi; see also Testimony of Sara Ross.] Finally, statements of OIC counsel at hearing advised that it was selecting which carriers whose plans it disapproved on July 31 to negotiate with post-July 31 – and advised that those carriers did not include this Company. [Transcript of proceedings, at Day 3.]

OIC'S ADDITIONAL CONCERNS ABOUT FINAL ORDER

While these issues are related to the OIC's arguments above, and are repeated throughout the OIC's Motion, the fact should be addressed that the OIC has lodged at least four pages of serious assertions about the integrity of the Final Order and the Hearing Officer which cannot be ignored even when it is understood that the OIC chose to take just two days between the time it received the Final Order and the time it filed its Motion for Reconsideration. Specifically, the OIC asserts that the Final Order "*command*[ed]" and "*forced*" and "*compelled*" and "*coerced*" the OIC to approve the filings "*even though the filings were in violation of law*" and "*upon terms dictated by the Hearing Officer*" without authority to do so. The OIC asserts that "*The Final Order cites no*

authority ... 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." The OIC asserts that the Final Order "*change*[d] *a legal ruling as punishment for one of the parties' failure to cooperate with directives in an Order,*" and "*set[s] 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 broadcasts to every health carrier ... that, by demanding a hearing on any disapproved filing, they can force the OIC to fix their contracts for them, ...*" [Emphasis in original.] Further, the OIC asserts, incorrectly, that in the Final Order the Hearing Officer "*decid*[ed] *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*" and thereby "*made herself a material witness*" and [citing the admittedly inapplicable CJC 2.11(a), 2.11(1), (2)(d) 2.6(B)] "*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*" and implied that the Hearing Officer had "*personal knowledge of facts*" and/or was "*likely to be a material witness in this proceeding*" and further implies that the Hearing Officer should have disqualified herself for "*bias, prejudice, interest,...*" under RCW 34.05.425(3) (even though this statute requires that the OIC - not the Hearing Officer - must act yet the OIC made no mention of these concerns either before or during the hearing and indeed not until it had received the Final Order). Finally, at the end of the OIC's four pages dedicated to this topic, the OIC postulates that the "*OIC may be reading too much into the Final Order*[.]"

In response, first, the OIC certainly has read too much into the Final Order, and a careful reading and consideration of it should respond to many of the OIC's concerns. Second, as discussed in detail above, the OIC is simply incorrect in its statement that evidence of the OIC's settlement negotiations with other carriers which *was introduced by the Hearing Officer, not by either party* when in fact the evidence was introduced by the Company, and to some extent the OIC, and no evidence was *introduced by the Hearing Officer*. Third, the Final Order can only be based on the evidence presented at hearing. The problems with the OIC's arguments and evidence are detailed above. It is not possible to enter the Findings and Conclusions which the OIC suggests should have been made when the arguments made by the OIC were not consistent with its prior actions and statements to the Company, were on occasion contradictory even at hearing or at best unclear. It is also not possible to enter the Findings and Conclusions which the OIC suggests should have been made when the evidence presented by the OIC at hearing was on some occasions contrary to what it now argues, and was inconsistent over time even during the course of the hearing, and on other occasions was either nonexistent or insufficient. In addition, as also discussed above in more detail, the OIC's presentation of evidence was limited by the fact that two of the OIC's three witnesses had not even been involved in the filing process with this or perhaps any other carrier submitting filings for the Exchange. In addition, one admitted at hearing he had not even read the Company's entire filings, and the other admitted she was new to her position and not familiar with the ACA.

For all of the reasons discussed above, the OIC has failed to show any basis upon which reconsideration should be granted.

CONCLUSION

Based upon the above authorities and analysis, the OIC has not persuaded the undersigned that there are any issues of fact or law that warrant reconsideration of the Findings of Fact, Conclusions of Law and Final Order entered by the undersigned on September 3, 2013. Further, the OIC has not persuaded the undersigned that she committed error, manifest or otherwise, in entering her Findings of Fact, Conclusions of Law and Final Order in this matter. Therefore, the OIC has not made the requisite showing for reconsideration pursuant to state and federal rules and case law, and thus the OIC's Motion for Reconsideration should be denied.

ORDER

On the basis of the foregoing,

IT IS HEREBY ORDERED that the Insurance Commissioner's Motion for Reconsideration is **DENIED**.

ENTERED at Tumwater, Washington, this 15th day of November, 2013, pursuant to Title 34 RCW and specifically RCW 34.05.470; Title 48 RCW; and regulations pursuant thereto.

PATRICIA D. PETERSEN
Chief Presiding Officer

Pursuant to RCW 34.05.461(3), the parties are advised that, pursuant to RCW 34.05.514 and 34.05.542, this order may be appealed to Superior Court by, within 30 days after date of service (date of mailing) of this order, 1) filing a petition in the Superior Court, at the petitioner's option, for (a) Thurston County or (b) the county of the petitioner's residence or principal place of business; and 2) delivery of a copy of the petition to the Office of the Insurance Commissioner; and 3) depositing copies of the petition upon all other parties of record and the Office of the Attorney General.

Declaration of Mailing

I declare under penalty of perjury under the laws of the State of Washington that on the date listed below, I mailed or caused delivery through normal office mailing custom, a true copy of this document to the above identified individuals at their addresses listed above.

DATED this 18th day of November 2013.

KELLY A. CAIRNS