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February 18, 2014

VIA E-MAIL & HAND-DELIVERY

Jennifer J. Patterson
Life, Accident & Health Legal Counsel
State of New Hampshire, Insurance Department
21 South Fruit Street, Suite 14
Concord, NH 03301

Re: *In re Petition of Frisbie Memorial Hospital et al.*
INS. No. 13-038-AR

Dear Jennifer:

Enclosed please find for filing with the Department, Petitioners' Supplemental Filing Concerning Standing, relative to the above-referenced matter.

Thank you for your assistance.

Very truly yours,



John A. Malmberg

JAM/mem
Enclosure

cc: Maria Proulx, Esq. (via e-mail & first class mail)
1116848_1

THE STATE OF NEW HAMPSHIRE

INSURANCE DEPARTMENT

In re Petition of Frisbie Memorial Hospital *et al.*

INS. No. 13-038-AR

PETITIONERS' SUPPLEMENTAL FILING CONCERNING STANDING

Frisbie Memorial Hospital (“Frisbie”) and Margaret McCarthy (collectively the “Petitioners”) submit the following analysis of documentation submitted by Anthem Blue Cross Blue Shield of New Hampshire (“Anthem”) to support their claims of standing to obtain a hearing pursuant RSA 400-A:17:

1. Petitioners are aggrieved parties, because Anthem’s “narrow network” plans on the New Hampshire Health Insurance Marketplace (the “Marketplace”) are inadequate to ensure that the New Hampshire population served by those plans will have access to services without unreasonable delay. Because Anthem’s narrow network does not comply with either the Department’s regulations on network adequacy or federal standards for plans on the Marketplace, it is inadequate as a matter of law, and the Department erred in approving Anthem’s plans for sale on the Marketplace.

2. The Department’s error injured Frisbie directly by permitting Anthem to exclude Frisbie, when the network would have had to include Frisbie in order to be adequate. The omission of Frisbie directly injured Ms. McCarthy by forcing her to switch providers, or accept higher costs for insurance than she would have been able to pay if Frisbie were included in the Anthem network.

3. Given that the Department’s Commissioner and his staff were in attendance at the February 10, 2014 public hearing at which Frisbie presented argument

on this subject, Petitioners hereby incorporate by reference fully and completely herein: Frisbie's Written Comments, the presentation images submitted by Frisbie at the conclusion of the hearing, and the transcript, including the comments of members of the public, of the Department's public hearing on February 10, 2014 relating to Anthem's narrow network.¹

4. Under the Patient Protection and Affordable Care Act (the "ACA" or "Obamacare"), insurers are required to offer a health care services "network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay." 45 C.F.R. §156.230(a)(2). To meet this mandate, the Department turned to its existing standards for network adequacy for managed care plans. *See* N.H. Admin. R. Ins. 2700 *et seq.* (hereinafter "Ins. _____"); Ins. 2701.04(a) (describing broad adequacy standard to be met by managed care plans).

5. Unfortunately, Anthem's narrow network was approved by the Department despite the fact that it did not meet those standards.

6. Ins. 2701.06(b)(1) required Anthem to ensure that its network included at least two primary care providers ("PCPs") who are accepting new patients within 15 miles or 40 minutes of 90% of its enrolled population.

a. This standard was not met because (i) Anthem submitted no data at all concerning which of its in-network PCPs were accepting new patients; and ii) Anthem did not analyze either where its new members would be situated or the proximity of those new members to providers accepting new patients. These

¹ Petitioners assume that the Department created a transcript or recording of the February 10, 2014 hearing. However, Frisbie can provide an information transcript of the February 10, 2014 hearing if the Department did not create a transcript.

omissions in and of themselves render the network proposed by Anthem prima facie inadequate. Ins. 2701.04(c) (requiring that all standards set forth in Ins. 2701.02-.09 be met to meet network adequacy).

b. The failure to analyze where Anthem would be drawing its new membership from is particularly noteworthy because the people in the areas where facilities were omitted from Anthem's network—including the northwest Strafford County area—are the least likely to have existing health insurance coverage, and the most likely to be purchasing a plan from Anthem on the Marketplace.

c. In Strafford County, for example, children in the "Rochester Analysis Area" designated by the Department of Health and Human Services are covered by commercial insurance only about 49% of the time, as compared to the "Dover Analysis Area" closest to Anthem's only in-network facility provider in Strafford County, where private commercial health coverage for children exceeds 65%. N.H. CHIP Report 2011. This suggests that about half the population in the Rochester Analysis Area will be eligible for (and required to purchase) a Marketplace available plan, as opposed to just 35% in Dover. Selecting a health care facility as the hub of services for Strafford County that is furthest from the population most likely to use those services likely violates the mileage and travel time requirements of Ins. 2701.06(a), and is the antithesis of network adequacy.

d. An adequate network to service these patients should have included Frisbie Memorial Hospital, and the Department's decision not to require either (i) the analysis that would have demonstrated that necessity, nor ii) the

inclusion of a facility (and its affiliated providers) that served primarily these patients was an error that injured both Frisbie and Mrs. McCarthy.

7. Ins. 2701.06(b)(2) requires Anthem to submit a “consumer survey” demonstrating that the network was offering a level of service that meets members’ needs for primary care availability.

a. Anthem did not submit such a survey. This renders Anthem’s network *prima facie* inadequate. Ins. 2701.04(c) (requiring fulfillment of all standards to receive approval).

b. Anthem’s and the Department’s assertion that the new Marketplace available products were not yet in existence, and therefore such a survey could not be completed or required, is incorrect.

c. First, it would be relatively straightforward to (i) determine which populations would be most likely to be purchasing health insurance through the Marketplace, where those people are more likely located, and (ii) survey those areas to assemble a statistically significant pool of respondents that would allow a valid survey of the kind required to be completed.

d. Second, Anthem is required to conduct this survey annually for its existing “open” HMO network. Assuming these surveys have been done previously, it would be easy to extrapolate what the removal of certain facilities and providers from the existing network would do in terms of patient access to health care providers. Alternatively, if no such survey was done in the previous decade, it is all the more important that such a survey be completed for plans involving a narrow network submitted on the Marketplace.

e. This was a particularly important standard to meet, given that Anthem's stated intention was to shrink the size of its provider network and drive up volume to a smaller number of providers. As Anthem repeatedly emphasized in its public pronouncements and its testimony, certain providers it wanted in the network would only accept Anthem's proffered rates if Anthem could direct patients who would ordinarily go elsewhere to those facilities. This rationale is neither consistent with the facts nor appropriate. Anthem included in its narrow network the two major providers in the same city—Catholic Medical Center and Elliot Hospital in Manchester—a location where that rationale would likely be especially applicable. Moreover, Anthem never even approached Frisbie to discuss rates. If it had, it would have learned that Frisbie is willing to accept the same rates being offered to other providers in Anthem's network. Thus the rationale is not legitimate. But assuming the rationale has some basis, determining how the current Anthem open network is meeting the health care needs of presently enrolled members is an essential baseline that must be established in order to understand the effects of removing entire provider networks wholesale—as Anthem did here to Frisbie.

8. Ins. 2701.07(a) required Anthem to meet waiting time standards for patients on the network as established by the National Council on Quality Assurance.

a. Anthem submitted no information on waiting times or the anticipated impact of its restricted narrow network on waiting times. Nor did Anthem submit analysis of waiting time compliance for its existing open network.

Without these analyses, Anthem's narrow network is *prima facie* inadequate. Ins. 2701.04(c).

b. Since driving higher volume to a smaller number of providers will unquestionably cause waiting times to increase, there is a real danger that they will exceed NCQA standards. But, there is no way to assess compliance with this requirement from the data Anthem submitted, and thus Anthem has failed to satisfy its burden to show that its proposed network complies with the Department's regulation.

9. Anthem failed to provide a comprehensive network adequacy report, as required by Ins. 2701.09. Although some of Anthem's submissions contained some of the data required under subsection 2701.09, there was no comprehensive report that addressed each particular standard and included or at least referred to the documentation demonstrating adherence. Nor was there any effort to describe the required plans for assessing and ensuring network adequacy over the long term.

a. For example, there was no geographic analysis including maps showing the residential location of covered persons in New Hampshire *as well as* providers. Ins. 2701.09(g)(3)(b). Anthem's GeoAccess maps were limited to provider location only.

b. There was no access table "illustrating the relationship between providers and covered patients by county or hospital service area, or on a statewide basis" (including, critically, the number of primary care providers accepting new patients, and those not accepting new patients and the percentage

of covered persons meeting provider access requirements for primary, specialty and institutional care). Ins. 2701.09(g)(3)(b).

c. There was no detail of Anthem's process for monitoring and assuring on an ongoing basis the adequacy of its network. Ins. 2701.09(g)(5). Nor was there a plan for providing services in rural or underserved areas and for developing relationships with essential community providers. Ins. 2701.09(g)(6).

d. Even if one assumes that the varied and disorganized materials submitted by Anthem constituted portions of the required data, there is indisputably no "network adequacy report" as required by Ins. 2701.09.

10. Although Anthem's network is inadequate as a matter of law without those submissions, *see* Ins. 2701.04(c), merely checking off those boxes will not make the network adequate. Frisbie believes that if the proper documentation had been submitted, it would have shown the network to be inadequate as constructed. At a minimum, network adequacy required Frisbie's inclusion, if not also that of the other omitted facilities and their affiliated providers.

11. Frisbie and Mrs. McCarthy are entitled to a determination that the Anthem "narrow network" is inadequate under Ins. 2701.02-09 without the inclusion of Frisbie, or, in the alternative, an adjudicative hearing at which the foregoing metrics for network adequacy will be analyzed with actual data, documents and testimony, not groundless assertions by Anthem.

12. The essence of Anthem's likely objection to Frisbie's request for an adjudicative hearing is that Frisbie cannot prove the foregoing network adequacy analysis, and thereby show standing to challenge the Department's decisions. The

Department should reject this argument for two reasons. First, the burden of proving network adequacy rests squarely on the insurer seeking approval. Ins. 2701.04(c). Second, one need not prove one's case to establish standing. The standing analysis rests upon a presumption that the assertions made by the claimant are true; or, if proven, that they would show that the claimant was a "person aggrieved" by the Department's decision—a person who had a direct interest in the outcome of the Department's decision making. *Golf Course Investors of NH, LLC v. Town of Jaffrey*, 161 N.H. 675, 680 (2011).

13. Because the narrow network omitted Frisbie when it should not have, Frisbie has a direct injury deriving from the Department's erroneous approval of the Anthem narrow network. Mrs. McCarthy has a direct injury because, as a consequence of the Department's approval of the Anthem narrow network, she is faced with the choice of losing her medical providers, with whom she has a longstanding relationship, or keeping them at a higher cost than she would have to pay on the Marketplace, without the option of subsidies. These are both sufficient direct injuries for each Petitioner to be entitled to an adjudicative hearing on the adequacy of Anthem's narrow network. *Golf Course Investors of NH, LLC v. Town of Jaffrey*, 161 N.H. at 680.

14. The Department's approval of Anthem's "narrow network" plans raises substantial public policy concerns about the good-faith implementation of the ACA. It is unfortunate, and conspicuous, that the populations in New Hampshire most burdened by access hurdles under the Anthem narrow network are some of the poorest in the state, including the much less well-off northwest section of Strafford County. *See Martin*,

Timothy and Weaver, Christopher, "Health Plans Avoid Poorer Areas," *Wall Street Journal*, February 16, 2014, attached hereto.

15. While the ACA's network adequacy standard is similar to the standard employed by the Department for evaluating the network adequacy of managed care plans, *see* N.H. Admin. R. Ins. 2701.04(a), it is important to note that the public interests addressed by the ACA are universal. Where a pre-ACA consumer had the voluntary choice to purchase a health insurance plan of his liking, or none at all, under the ACA all Americans are now required to either obtain health insurance coverage or pay a penalty. If no employer based coverage is available, consumers may purchase plans on the Marketplace. In fact, consumers must purchase health insurance on the Marketplace in order to benefit from the subsidies that make individual health insurance products affordable for most Americans. Therefore, for all practical purposes, a consumer making his or her own choice for insurance (as opposed to being told by an employer what insurance coverage he or she will have) is obligated to purchase on the Marketplace.

16. Because consumers are under a mandate to purchase health insurance, the transaction is very different from the pre-ACA purchase of an HMO plan. Where consumers had the option, then, of electing to purchase a PPO or other kind of insurance, or, alternatively, of not purchasing insurance at all, the public policy considerations in evaluating the network adequacy of an HMO were not the same. A consumer who did not like the proposed network available to him or her under the HMO could look elsewhere for coverage or choose to go without. The pre-ACA health insurance purchase was a simple commercial transaction, lacking the substantial public policy framework that supports and surrounds the post-ACA health insurance transaction.

17. The goal of the ACA is to provide affordable, quality health insurance coverage for every American. Therefore, unlike the pre-ACA purchase of health insurance, the individual purchase of a health insurance policy is now more than just a simple commercial transaction. It is the fulfillment of a policy intended to promote health insurance coverage, reduce economic hardship, improve access to care in appropriate settings, and control health care costs.

18. For these reasons, simple reliance upon standards created to regulate HMO networks in the pre-ACA era is not enough. While existing N.H. regulations may be appropriate as guidelines in meeting the access standards called for by the ACA, they must be read in light of the ACA's overarching goals and objectives, and, if necessary, exceeded in order to meet those goals and objectives.

19. Therefore even if Anthem had met the letter of the managed care network adequacy provisions requirements described in 2700 *et seq.*, which it did not, the Department should not have approved a proposed health care network that omitted some of the poorest areas of New Hampshire, including the relatively less well off, less insured, poorer and more unemployed portions of Strafford County served primarily by Frisbie and its affiliated providers. Anthem's "narrow network," in other words, would not have been sufficient to meet the network adequacy requirements of the ACA *even if* it had met the minimum standards described in N.H. Admin. R. Ins. 2700.

20. The Department failed to ensure that Anthem's narrow network for Marketplace available plans was adequate under Ins. 2700 *et seq.*, and the ACA. The network was inadequate, *prima facie*, due to Anthem's failure to file the information required to evaluate network adequacy. Ins. 2701.04(c) (requiring fulfillment of all

standards in Ins. 2701.02-09 in order to demonstrate network adequacy). But the submission of the correct information would only have revealed the network to be substantively inadequate as well, due to excessive waiting times and geographic distances to providers.

WHEREFORE, for the foregoing reasons, the Petitioners request that the Department:

- A. Determine that the Petitioners have standing to obtain an adjudicative hearing pursuant to RSA 400-A:17;
- B. Determine that the network of health care providers offered by Anthem on its Marketplace-available plans is inadequate to meet the standards enunciated in the ACA and in the Department's own network adequacy regulations;
- C. Require Anthem to negotiate in good faith with Frisbie to add Frisbie to Anthem's network at commercially reasonable rates;
- D. Or, in the alternative, grant the Petitioners an adjudicative hearing pursuant to RSA 400-A:17 to create a record concerning the network adequacy of Anthem's Marketplace available health insurance plans; and
- E. To grant such other and further relief as the Department has authority to grant and deems to be necessary under the circumstances.

Respectfully submitted,

Frisbie Memorial Hospital
Margaret McCarthy

Date: February 18, 2014

By:


John A. Malmberg, No. 1600

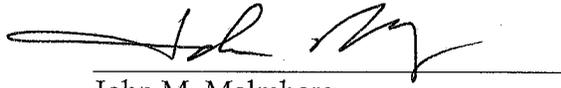
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CERTIFICATE OF SERVICE

I hereby certify that a copy of the foregoing was forwarded, this day, by first class mail and electronic mail, to Maria Proulx, Esq., counsel for Anthem.

Date: February 18, 2014



John M. Malmberg

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THE AGGREGATOR

Health Plans Avoid Poorer Areas

Hundreds of thousands of Americans in poorer counties have few choices of health insurers and face high premiums through the online exchanges created by the health-care law, according to an analysis by The Wall Street Journal of offerings in 36 states.

Consumers in 515 counties, across 15 states, have only one insurer selling coverage through the exchanges, the Journal found. In more than 80% of those counties, the sole insurer is a local Blue Cross & Blue Shield plan. Residents of wealthier, more populated counties receive lower-priced choices than those in counties with a single insurer.

On Wednesday, the administration reported about 3.3 million people had signed up for coverage through the online marketplace by Jan. 31, an increase of more than one million since December, but with fewer young people than needed to restrain premiums.

Higher participation rates among young adults—as much as 40% of the total group buying coverage on the exchanges—is seen as essential to balance out the higher costs of covering older people for insurers that are already limiting the counties where they offer coverage.

The average price for a 50-year-old American to obtain the cheapest midlevel “silver plan” through HealthCare.gov—the marketplace operated by the federal government—was \$406 a month in counties with one health insurer, The Journal found. In counties with four insurers, the cheapest silver plans averaged \$329.

The price differences reflect the strategy of insurers picking markets where they believe they can turn a profit and avoiding areas of high unemployment and a concentration of unhealthy residents they deem more risky.

As Aetna Chief Executive Mark Bertolini said last fall: “We were very careful to pick the markets” where the insurer could succeed.

—Timothy W. Martin
And Christopher Weaver
The Wall Street Journal