IN THE DISTRICT COURT OF THE FOURTH JUDICIAL DISTRICT OF

THE STATE OF IDAHO IN AND FOR THE COUNTY OF ADA

BRIDGESPAN HEALTH COMPANY,
Certificate of Authority No. 4185
NAIC ID No. 95303

Petitioner,

vs.

STATE OF IDAHO, DEPARTMENT OF INSURANCE,

Respondent.

CASE NO. CV01-18-2382

MEMORANDUM DECISION ON PETITION FOR JUDICIAL REVIEW

INTRODUCTION

BridgeSpan is a Utah corporation that services consumers in the individual health insurance market under the Patient Protection and Affordable Care Act. BridgeSpan's first Idaho individual market policies were effective as of January 1, 2014. The Exchange is Idaho's voluntary health insurance marketplace, created pursuant to an act of the Legislature, and carriers offering products in the individual market have the option to sell "qualified health plans" via the Exchange. Under federal law, carriers offering products on the Exchange must allow consumers to purchase such products off the Exchange.

Beginning in 2015, BridgeSpan argues that it filed its products with the Idaho Department of Insurance ("DOI") as being available both on- and off-Exchange, in accordance with guidance from the US Department of Health and Human Services ("HHS"); however, no consumers elected to purchase BridgeSpan products off the Exchange.

In early 2017, BridgeSpan made the decision to decertify its plans from the Exchange and move exclusively to an off-Exchange distribution model. On May 12, 2017, BridgeSpan representatives informed the DOI that BridgeSpan intended to decertify its products from the

Exchange. That same date, BridgeSpan filed proposed 2018 plan documents with the DOI through the System for Electronic Rates & Forms Filing ("SERFF") and informed both the Exchange and Governor C.L. "Butch" Otter of its decision to decertify. On May 15, BridgeSpan representatives again met with the DOI to discuss Exchange decertification.

During these initial discussions, the DOI asserted that BridgeSpan's 2018 plans and decision to decertify from the Exchange would trigger a five-year exclusion penalty under Idaho Code section 41-5207. Idaho Code section 41-5207 generally states that individual health plans are renewable at the option of the individual, unless an exception applies. On June 14, 2017, the DOI served BridgeSpan with a Notice of Disapproval letter stating that BridgeSpan's 2018 filings would be disapproved if no modifications were made to address the requirements of Idaho Code section 41-5207. On June 19, 2019, the DOI lodged an objection in SERFF referencing the Notice of Disapproval letter and informing BridgeSpan again that its 2018 filings would be disapproved unless changes were made to address Idaho's guaranteed renewal statutes. On July 18, 2017, the DOI lodged a second objection in SERFF; however, no agreement could be reached between BridgeSpan and the DOI to resolve those objections.

On July 25, 2017, the DOI issued an Order to Show Cause and Notice of Hearing directing BridgeSpan to appear and show cause why it should not be prohibited from writing new business in the individual market in Idaho for a period of five years under Idaho Code section 41-5207. The Order referred to DOI's Motion for an Order to Show Cause, which proposed the penalties against BridgeSpan based on its "notice of its intent to not renew the individual benefit plans that it offers on the Your Health Idaho exchange ('the Exchange'), which equates to nonrenewal of all of its health benefit plans delivered to individuals in the State."

On August 15, 2017, BridgeSpan filed its Answer and Pre-Hearing Brief, asserting that federal guaranteed renewability rules at 45 C.F.R. § 147.106 preempt Idaho Code section 41-5207 and require BridgeSpan to give current enrollees the opportunity to renew coverage off the Exchange. BridgeSpan also argued that its proposed 2018 individual market plans met the Uniform Modification Rules. The Director of DOI conducted a hearing on the Order to Show Cause over four days: August 25, 2017; September 7, 2017; September 18, 2017; and October

23, 2017. BridgeSpan presented its case-in-chief on the first day, August 25, 2017. The DOI presented its evidence on each of the three following days.

On January 8, 2018, the Director issued a Decision and Order prohibiting BridgeSpan from writing any new business in the individual health insurance market in Idaho for five years beginning May 12, 2017. The Director concluded that: (1) BridgeSpan's 2018 filings constituted an election to nonrenew all of its individual health benefit plans under Idaho Code section 41-5207(1)(f); and, (2) BridgeSpan's plans did not meet the "safe harbor" established by the federal guaranteed renewability rules. On February 5, 2018, BridgeSpan timely filed a petition for judicial review of the Director's decision.

STANDARD OF REVIEW

Judicial review of an agency action is governed by the Idaho Administrative Procedure Act ("IDAPA"). I.C. § 67-5270(1). The IDAPA requires a reviewing court to "affirm the agency action unless the court finds that the agency's findings, inferences, conclusions, or decisions are: (a) in violation of constitutional or statutory provisions; (b) in excess of the statutory authority of the agency; (c) made upon unlawful procedure; (d) not supported by substantial evidence on the record as a whole; or (e) arbitrary, capricious or an abuse of discretion." I.C. § 67-5279(3). The petitioner has the burden of showing that the board erred in a manner specified in Idaho Code section 67-5279(3) and that a substantial right of the petitioner has been prejudiced. I.C. § 67-5279(4); *Barron v. Idaho Dep't of Water Res.*, 135 Idaho 414, 417, 18 P.3d 219 (2001).

The "Court will not substitute its judgment for that of the board regarding the weight of the evidence on questions of fact." *Wohrle v. Kootenai Cty.*, 147 Idaho 267, 274, 207 P.3d 998, 1005 (2009); I.C. § 67-5279. "A reviewing court defers to the agency's findings of fact unless they are clearly erroneous, and the agency's factual determinations are binding on the reviewing court, even when there is conflicting evidence before the agency, so long as the determinations are supported by substantial competent evidence in the record." *Idaho Ground Water Assoc. v. Idaho Dep't of Water Res.*, 160 Idaho 119, 125, 369 P.3d 897, 903 (2016), reh'g denied (May 9, 2016) (internal quotations omitted). "Discretionary decisions of an agency shall be affirmed if the agency (1) perceived the issue in question as discretionary, (2) acted within the outer limits of its discretion and consistently with the legal standards applicable to the available choices, and (3) reached its own decision through an exercise of reason." *Id.*

ANALYSIS

BridgeSpan argues that this Court should vacate the Director's Decision and Order for three reasons: (1) the Director failed to recognize that the federal guaranteed renewability and Uniform Modification Rules preempt application of the narrower state guaranteed renewability rules at Idaho Code section 41-5207; (2) the Director's determination that BridgeSpan's 2018 plan changes did not meet two of the federal Uniform Modification Rules is contrary to law and arbitrary and capricious; and, (3) the DOI violated BridgeSpan's procedural due process rights by failing to provide pre-hearing notice of the statutory basis of its exclusion.

A. Federal Preemption

BridgeSpan argues that the Director made it clear that his Decision and Order rested on his interpretation of Idaho Code section 41-5207, and that the Director failed to recognize the full scope and effect of federal preemption by the Uniform Modification Rules in 45 C.F.R. § 147.106(e)(3). BridgeSpan concludes:

> Accordingly, the Director's analysis of the interaction between Idaho Code § 41-5207 and the Uniform Modification Rules misses the fundamental point that, whether or not BridgeSpan's particular plan changes comply with Idaho Code § 41-5207, the outcome turns exclusively on BridgeSpan's compliance with the Uniform Modification Rules. Stated another way, if BridgeSpan's proposed 2018 filings do comply with the Uniform Modification Rules, then federal law requires Idaho to make BridgeSpan's 2018 products available for renewal on an off-Exchange basis, and the Director's lengthy discussion of whether year-over-year changes to BridgeSpan's 2018 plans constitute nonrenewals under Idaho Code § 41-5207 (R. 324-26) is moot; if BridgeSpan's proposed 2018 plans do not comply with the Uniform Modification Rules, then federal law would require the DOI to deem the BridgeSpan's plans terminated, regardless of whether the plan changes otherwise fail to comply with Idaho Code § 41-5207. In short, the Director's reliance on Idaho Code § 41-5207 at all is misplaced.

BridgeSpan's argument is without merit. In his Decision and Order, the Director clearly presented his analysis as to how and why the DOI determined that BridgeSpan was not offering the same plans for renewal and an analysis of how and why BridgeSpan's new plans were not "Uniform Modifications" pursuant to 45 C.F.R. § 147.106(e)(3). The Decision and Order contains an entire section titled: "Do the federal guaranteed renewability and uniform modification rules preempt Idaho's guaranteed renewability statute?" The Decision and Order provides in relevant part:

> The federal rule provides that a modification made by a health carrier pursuant to a requirement of applicable federal or state law is a modification of the same product. 79 F.R. 30248. However, as in the instant case, where a health carrier makes a modification not mandated by federal or state law, such change would be considered an EUMC only if the product meets the criteria identified above under 45 C.F.R. § 147.106(e)(3). *See*, 79 F.R. 30248.
>
> The issue then is whether BridgeSpan's 2018 individual health benefit plans are compliant with the EUMC rule, thereby conceding to BridgeSpan a "safe harbor" from the guaranteed renewability of coverage mandate under federal law. *See*, 45 C.F.R. § 147.106(e)(3).

(emphasis original). The Director clearly recognized the preemptive nature of the federal guaranteed renewability and uniform modification rules and conducted his analysis accordingly. The DOI has not attempted to argue that the Director's decision may be upheld under Idaho Code section 41-5207 regardless of whether BridgeSpan complied with the Uniform Modification Rules in 45 C.F.R. § 147.106(e)(3), thus, for the purposes of this appeal, BridgeSpan's argument that the Director failed to somehow expressly acknowledge that the federal regulations completely preempt Idaho Code is moot.

B. The Director's analysis under the Uniform Modification Rules.

BridgeSpan argues that the Director's determination that BridgeSpan's 2018 plan changes did not meet two of the federal Uniform Modification Rules is contrary to law and arbitrary and capricious. The Director concluded that BridgeSpan's plan changes did not comply with two of the five Uniform Modification Rules criteria. Specifically, the Director concluded that: (1) BridgeSpan's proposed 2018 products do not have the same product network type; and, (2) the proposed plans do not have the same cost-sharing structure.

a. Product Network Type

In his Decision and Order, the Director determined that BridgeSpan's new plan offerings did not meet the requirements for a uniform modification exception under 45 C.F.R. § 147.106(e)(3)(ii), which provides: "The product is offered as the same product network type (for example, health maintenance organization, preferred provider organization, exclusive provider organization, point of service, or indemnity)." The Decision and Order provides in full:

> A review of the product network type will be examined at the product level. A "product' is defined by federal rules as
>
> > [a] discrete package of health insurance coverage benefits that are offered using a particular product network type (such as health

> maintenance organization [HMO], preferred provider organization [PPO], exclusive provider organization [EPO], point of service, or indemnity) within a service area.

45 C.F.R. § 144.103 (underscore here).

In 2017, BridgeSpan offered a product identified as HIOS Product No. 5971D009 with five plans, identified as follows:

59765ID0090001	Silver HDHP 3000
597 65ID0090002	Bronze HDHP 6000
597 65ID0090003	Gold Essential 1200
597 65ID0090004	Silver Essential 4000
597 65ID0090005	EPO Bronze Essential 7150

Exhibit F. All five plans are identified by BridgeSpan as a "preferred provider organization" type of plan. *Id*. BridgeSpan claims all five plans were available off and on the Exchange; albeit for years 2014 through 2017, BridgeSpan failed to file any off-Exchange individual health benefit policy forms or applications with the Department as required. *Id. See*, Tr. 279:7-19; 282:18-283:11. Under Idaho law, no policy forms or applications may be delivered or issued for delivery in the state of Idaho, unless such forms or applications are first filed with the Department. Section 41-1812(1), Idaho Code.

In its 2018 filings, the four plans offered by BridgeSpan-and asserted by BridgeSpan to be the same as four of the above-listed 2017 plans (with one exception, namely the "Gold Essential 1200)-are identified in title as "exclusive provider organization" ("EPO") plans. Exhibit E. As previously stated above, the federal website, HealthCare.gov identifies an EPO as a type of managed care plan where, except in cases of emergency, services are covered only if an insured uses the providers, specialists, and hospitals in the plan's network. A true EPO has no out-of-network benefit. Tr. 100:6-10. Idaho recognizes three product network types, as provided under Idaho Code, including an "indemnity" type, where there is no provider network, a preferred provider organization or PPO, and a managed care organization. Tr. 356:1-7. Idaho law requires managed care plans to cover all or a portion of the cost of out of network services. *See*, section 41-3905(3), Idaho Code. Tr. 87:16-25.

BridgeSpan's 2017 filings show the plans to be a PPO product network type. Exhibit F. In its 2018 filings, BridgeSpan identified its proposed plans as an EPO product network type. *See*, Exhibits C, D. and E. Yet, at hearing, BridgeSpan identified the 2018 filings as a PPO product network type. Tr. 123:7-30; 137:17-18. BridgeSpan argues that identifying the various types of plans, including PPO and EPO, is a challenge under Idaho law. Tr. 107:18-25; 108:21-25; 109:1-4; 110:1-8. It is partly that muddled interpretation and lack of clarity, as revealed in the record surrounding its 2018 filings, which leads the Director to conclude that the BridgeSpan 2018 filings are not the same product network type as the 2017 plans.

> The 2018 filings include a change in out-of-network cost-sharing coinsurance from 50% for 2017 to 90% for 2018. In addition, for 2018, BridgeSpan changed its network from a "preferred network" to a "Medical Neighborhood" network. Tr. 90: 24-25; 91:1-4. This change added a subnetwork or selection feature. Tr. 84: 9-16.
>
> The Director finds there is a significant change in the product network type, as the 2018 plans more closely resemble a managed care product type than any other product type contemplated under Idaho law. Therefore, BridgeSpan's 2018 filings fail to satisfy romanette (ii) of the EUMC at 45 C.F.R. 147.106(e)(3).

BridgeSpan argues that this conclusion is: (1) contrary to law because it directly conflicts with the clear statutory definition of "nonmanaged care"; and, (2) the conclusion is arbitrary and capricious because it unreasonably relies on evidence that the Legislature did not intend it to consider in making distinctions between network types. Specifically, BridgeSpan argues that the director's definition of "managed care" is contrary to Idaho Code section 41-3903(15), which provides:

> A person holding a license to transact disability insurance offering a health plan that creates financial incentives to use contracting providers may elect to file the plan as a nonmanaged care plan not subject to the provisions of this chapter if the health plan reimburses providers solely on a fee for service basis and does not require the selection of a primary care provider.

I.C. § 41-3903(15). BridgeSpan contends that the Director erred in concluding that BridgeSpan's plans were more like "managed care" plans because BridgeSpan's plans allow for Medical Neighborhoods in which there are multiple medical providers and there is no requirement that a person select a Primary Care Physician (PCP). Thus, BridgeSpan argues that the Director's decision is contrary to Idaho statute and the definition of "nonmanaged care" contained in Idaho Code section 41-3903(15). BridgeSpan is incorrect.

The Court notes that BridgeSpan's primary argument on appeal is misleading. Throughout its briefing and during oral argument BridgeSpan continuously referred to the "definition of 'nonmanaged care' contained in Idaho's Insurance Code." However, that argument relies on a selective and inaccurate interpretation of the Idaho Code. Idaho Code section 41-3903(15) provides a definition of "managed care plan," not "nonmanaged care." The full text of Idaho Code section 41-3903 provides:

> **"Managed care plan" means a contract of coverage given to an individual, family or group of covered individuals pursuant to which a member is**

> **entitled to receive a defined set of health care benefits through an organized system of health care providers in exchange for defined consideration and which requires the member to use, or creates financial incentives for the member to use, health care providers owned, managed, employed by or under contract with the managed care organization.** *A person holding a license to transact disability insurance offering a health plan that creates financial incentives to use contracting providers may elect to file the plan as a nonmanaged care plan not subject to the provisions of this chapter if the health plan reimburses providers solely on a fee for service basis and does not require the selection of a primary care provider.* The election to file a health plan as a nonmanaged care plan shall be made in writing at the time the plan is filed with the director pursuant to chapter 18, title 41, Idaho Code.

I.C. § 41-3903(15) (emphasis added). In fact, BridgeSpan's 2018 plans that contain a Medical Neighborhood Network appear to fit the definition of a "managed care plan" quite well. What BridgeSpan has selectively chosen to argue by quoting only the middle portion of Idaho Code section 41-3903(15) is an exception that may apply to "managed care plans" by which a provider that offers "managed care plans" may elect to file its plan as a "nonmanaged care plan" if two criteria are met. Idaho Code section 41-3903(15) does not contain a definition of a "nonmanaged care plan." As such, the Court cannot find that the Director's conclusion was contrary to Idaho statute.

Next, BridgeSpan argues that the Directors decision was arbitrary and capricious because it unreasonably relies on evidence that the Legislature did not intend it to consider in making distinctions between network types. BridgeSpan contends that: (1) there was conflicting evidence in the record as to whether the DOI gave BridgeSpan flexibility to categorize its 2018 plans for consumers as EPOs vs PPOs; and, (2) that the Director improperly relied on the definition of EPO found on the healthcare.gov website. BridgeSpan is incorrect.

"A reviewing court defers to the agency's findings of fact unless they are clearly erroneous, and the agency's factual determinations are binding on the reviewing court, even when there is conflicting evidence before the agency, so long as the determinations are supported by substantial competent evidence in the record." *Idaho Ground Water Assoc.*, 160 Idaho at 125, 369 P.3d at 903, reh'g denied (May 9, 2016). While BridgeSpan may argue that the evidence in the record did not support the Director's decision, this Court will not overturn an agency's factual findings unless those determinations are not supported by substantial competent evidence in the record.

As noted by the DOI, the Director's findings were made after thorough consideration of four days of testimony, over a thousand pages of documentation, after which the Director concluded that BridgeSpan's Medical Neighborhood Network: (1) added a selection element where none existed before; (2) reduced the choice of primary care providers from 3,085 in 2017 to 1,097 in 2018; and, (3) dramatically changed the out-of-network costs-share from 50% to 90%. The Decision and Order provides extensive citation to the evidence considered and relied upon by the Director.

Thus, the Court concludes that substantial competent evidence in the record supports the Director's determination that BridgeSpan's 2018 filings more closely resemble a managed care product, rather than any other product network type recognized under Idaho law, and that BridgeSpan's 2018 filings fail to satisfy romanette (ii) of the EUMC at 45 C.F.R. 147.106(e)(3).

b. Cost-Sharing Structure

In his Decision and Order, the Director determined that BridgeSpan's new plan offerings did not meet the requirements for a uniform modification exception under 45 C.F.R. § 147.106(e)(3)(iv), which provides: "Within the product, each plan has the same cost-sharing structure as before the modification, except for any variation in cost-sharing solely related to changes in cost and utilization of medical care, or to maintain the same metal tier level described in sections 1302(d) and (e) of the Affordable Care Act." The Decision and Order provides:

> The cost-sharing structure consists of the deductible, coinsurance, co-payments, and out-of-pocket maximums and, when taken together, is a mechanism to allocate the cost of the medical service between the insurer and the consumer. *Burwell*, 185 F.Supp. 3d at 171. *See*, Tr. 141:1-9. While the federal renewability statute has been interpreted at the product level, "in accordance with [HHS] definitions of 'product' and 'plan,' [HHS] note[s] that cost-sharing applies at the plan level." 79 F.R.30251. The term "plan" means:
>
> > With respect to a <u>product</u>, the pairing of the health insurance coverage benefits under the <u>product</u> with the particular cost-sharing structure, provider network, and service area. The <u>product</u> comprises all <u>plans</u> offered with those characteristics and the combination of the service areas for all <u>plans</u> offered within a <u>product</u> constitutes the total service area of the <u>product</u>
>
> 45 C.F.R. § 144.103 (underscore here). To be the same product, each plan within the product must have the same cost-sharing structure as before the modification, "except for any variation in cost-sharing solely related to change in cost and

> utilization of medical care, or to maintain the same metal tier level .... " 45 C.F.R. § 147.106(e)(3)(iv). In the instant case, in its 2018 filings, BridgeSpan modified the cost-sharing structure by significantly increasing the out-of-pocket percentage home by the insured for out-of-network providers from 50% to 90%. Exhibit D. Tr. 116-117; 150:19-151:1. BridgeSpan claims this modification in the out-of-network cost-sharing structure lacks actuarial significance. Tr. 145:9-18. The Department's witness acknowledged that the actuarial value of a plan is not impacted by out-of-network benefits. Tr. 535:16-25. The overall purpose of the modification appears to be to cover additional costs or to discourage enrollment. The Department notes, however, that the modification is a strong incentive for the healthcare consumer to stay in-network. The Department also claims the modification is not an inflationary necessity, but a move toward an exclusive provider organization that has no out-of-network benefits. Tr. 262:4-25.
>
> With regard to the issue of cost-sharing structure modifications, CMS, the responsible oversight agency at the federal level, stated that CMS will defer to a state's "reasonable interpretation" of 45 C.F.R. § 147.106(e)(3)(iv). *See*, CMS Bulletin, dated June 15, 2015, "Uniform Modification and Plan/Product Withdrawal FAQ," p. 3. The increase in percentage from 50% to 90% out-of-network cost-sharing coinsurance is substantial and unreasonable. *See*, 79 F.R. 30251. In addition, BridgeSpan increased the out-of-pocket maximums in all four of its 2018 plans. Therefore, the Director finds that the cost-sharing structure in BridgeSpan's 2018 filings is not the same as provided in its pre-2018 filings as defined under the term "Plan" in 45 C.F.R. § 144.103, in accord with 45 C.F.R. § 147.106. In sum, BridgeSpan's 2018 filings fail to satisfy romanette (iv) of the EUMC at 45 C.F.R. 147.106(e)(3).

BridgeSpan argues that the Director's analysis of BridgeSpan's cost-sharing structure is arbitrary and capricious because the decision represents a significant and unexplained departure from prior DOI practice. BridgeSpan contends that the DOI's witness, Mr. Trexler, acknowledged in testimony that the DOI has allowed other carriers to make significant changes to out-of-network copayments, deductible, and out-of-pocket maximums without invoking the Uniform Modification Rules.

> Q: There actually have been pretty significant changes within a cost-sharing structure in prior years without drawing objection from the Department of Insurance; haven't there?
>
> A: I don't recall the full objections that have been submitted in prior years. There were changes—substantial changes in cost-sharing in prior years.
>
> Q: Between 2016 and 2017 Select health (inaudible) Silver made some pretty dramatic changes within a cost-share structure; is that correct?
>
> A: Between '16 and '17 for Select Health?

> Q: Correct.
>
> A: That is my understanding. That they did make changes to their cost-sharing structure as well.
>
> Q: And did the Department of Insurance object to those?
>
> A: I would have [to] pull up the record. I don't have the record.
>
> Q: In the past isn't it true that the Department of Insurance simply hasn't considered changes in out of network co-payments, deductibles, and out of pocket maximums material to a plan's cost-sharing structure?
>
> A: I don't think we have taken that position.
>
> Q: Let me ask my question again. I'm not sure you responded. Isn't it true that the Department of Insurance simply hasn't considered changes in out of network co-payments, deductibles, and out of pocket maximums material to a plan's cost-sharing structure?
>
> A: I can't say that that is accurate, no. I think it depends on the changes they propose. And there have been some large changes. I agree.

Tr. Vol. III, pp. 541-42. BridgeSpan points to Idaho case law for the proposition that:

> Because regulatory bodies perform legislative as well as judicial functions in their proceedings, they are not so rigorously bound by the doctrine of stare decisis that they must decide all future cases in the same way as they have decided similar cases in the past. If, however, the [Agency] decides a case in a manner contrary to prior [Agency] rulings the Court will consider whether the [Agency] has adequately explained the departure from prior rulings so that a reviewing court can determine that the decisions are not arbitrary and capricious.

Rosebud Enterprises, Inc. v. Idaho Pub. Utilities Comm'n, 128 Idaho 609, 618, 917 P.2d 766, 775 (1996) (internal citations omitted). BridgeSpan concludes that DOI has not, until now, considered cost-sharing for out-of-network services material to a plan's cost-sharing structure; therefore, the Director's decision is arbitrary and capricious. BridgeSpan's arguments are unpersuasive.

Whether or not the DOI has previously considered cost-sharing for out-of-network services material to a plan's cost-share structure is immaterial to the analysis of whether BridgeSpan's 2018 plans constitute a uniform modification exception under 45 C.F.R. § 147.106(e)(3)(iv). The Director's analysis correctly notes that: "The cost-sharing structure consists of the deductible, coinsurance, co-payments, and out-of-pocket maximums and, when taken together, is a mechanism to allocate the cost of the medical service between the insurer and the consumer. *Burwell*, 185 F.Supp. 3d at 171." The standard to determine what constitutes

a change in a product's cost-sharing structure is laid out in 45 C.F.R. § 147.106(e)(3)(iv), which provides that only "variation in cost-sharing solely related to changes in cost and utilization of medical care, or to maintain the same metal tier level" are allowed. The Director based his conclusion on testimony from both BridgeSpan and the DOI that the modification in the out-of-network cost-sharing structure lacked any actuarial significance and that the modification was not an inflationary necessity, nor necessary to maintain the same metal tier level, but more aligned with a move toward an exclusive provider organization that has no out-of-network benefits.

Further, BridgeSpan's contention that the DOI has not previously considered cost-sharing for out-of-network services material to a plan's cost-sharing structure is not supported by the record. At best, the testimony provided by Mr. Trexler indicates that there have been some "substantial" and "large" changes in out of network co-payments, deductibles, and out of pocket maximums submitted to the DOI by other health insurance provides; however, nothing in the record indicates what "substantial" or "large" means in a practical sense. There are no records for the Court to consider showing if those "substantial" or "large" changes were necessary in response to the inflation of medical costs, or to maintain the same metal tier level as provided for under the uniform modification rules. Simply put, BridgeSpan has not shown that the DOI has decided a case in a manner contrary to its prior rulings. *Rosebud Enterprises, Inc.*, 128 Idaho at 618, 917 P.2d at 775. Thus, the Court cannot find that the Director's determination that BridgeSpan's new plan offerings did not meet the requirements for a uniform modification exception under 45 C.F.R. § 147.106(e)(3)(iv) was arbitrary and capacious.

C. Procedural Due Process

BridgeSpan argues that the DOI violated BridgeSpan's procedural due process rights by failing to provide pre-hearing notice of the statutory basis of its exclusion. BridgeSpan contends that the DOI did not provide BridgeSpan any pre-hearing notice that: (1) cost-sharing structure or product type would be specific issues in this proceeding, or, (2) DOI considered such issues dispositive to its nonrenewal determination. BridgeSpan contends:

> Although BridgeSpan raised the issue of "uniform modification" as a defense in its prehearing brief, BridgeSpan had no expectation that its defense would convert the hearing into an examination of BridgeSpan's minor year-over-year plan changes. It expected, as did Mr. Trexler, that this proceeding would

focus on whether plan decertification from the Exchange was a complete market withdrawal.

BridgeSpan's procedural due process arguments are without merit.

Idaho Codes section 67-5242 provides the notice requirement in an agency action:

(1) In a contested case, all parties shall receive notice that shall include:
(a) a statement of the time, place, and nature of the hearing;
(b) a statement of the legal authority under which the hearing is to be held; and
(c) a short and plain statement of the matters asserted or the issues involved.

I.C. § 67-5242. The DOI's Motion for an Order to Show Cause and Memorandum in Support Therof provides:

> Pursuant to Idaho Code § 41-5207(1)(f), if an individual carrier elects to nonrenew all of its health benefit plans delivered or issued for delivery to individuals in the State, the carrier must provide notice to the Director at least three working days (3) in advance of notice to affected individual and must provide notice to a carrier that elects to nonrenew all of its individual health benefit plans is thereafter prohibited from writing new business in Idaho's individual market for a period of five (5) years from the date of notice to the Director. See Idaho Code 41-5207(2).
>
> Approximately, nineteen thousand four hundred fifty-two (19,452) Idaho residents are enrolled in health benefit plans offered by RESPONDENT through the Exchange. RESPONDENT has no enrollees in health benefit plans off-Exchange. (Aff. of Trexler, P.2, ¶4.) RESPONDENT's enrollees through the Exchange constitute all of its business in the individual market in the State. (Aff. of Trexler, P.2, ¶4.) Respondent currently does no other insurance business in the State.
>
> On May 12, 2017, RESPONDENT filed its 2018 health benefit plan forms ("2018 Filings") with the Department. (Aff. of Trexler, P.2, ¶5.) The 2018 Filings list new forms offered by RESPONDENT for sale and enrollment off-Exchange and no forms that would be offered through the Exchange, including no renewals of existing policies. (Aff. of Trexler, P.3, ¶7.) **The new forms offered off-Exchange described in the 2018 Filings do not equate to any health benefit plans in which the RESPONDENT currently has enrollees.** (Aff. of Trexler, P.3, ¶¶ 7and 8.) Individuals currently enrolled with RESPONDENT will not be able to renew their existing policies as the existing policy forms were not part of RESPONDENT's 2018 Filings. (Aff. of Trexler, P.3, ¶¶ 7 and 8.)

(emphasis added). BridgeSpan's contention is disproven by the record. "Procedural due process requires some process to ensure that the individual is not arbitrarily deprived of his or her rights in violation of the state or federal constitutions. This requirement is met when the defendant is

provided with notice and an opportunity to be heard. The opportunity to be heard must occur at a meaningful time and in a meaningful manner in order to satisfy the due process requirement." *Neighbors for a Healthy Gold Fork v. Valley Cty.*, 145 Idaho 121, 127, 176 P.3d 126, 132 (2007) (internal citations omitted). As noted by DOI:

> It is ironic that BridgeSpan now claims a violation of its procedural Due Process rights based on failure to receive notice that its own defense and the evidence presented in support thereof would be weighed and considered by the Director in his final Decision and Order.

The Court agrees. BridgeSpan received notice that its changes to its filings for the 2018 plans were at issue. BridgeSpan was also provided with a meaningful hearing that lasted four days and BridgeSpan was given the opportunity to present evidence and testimony. BridgeSpan called four witnesses to testify on its behalf. The hearing itself took place over a two-month period, during which BridgeSpan was allowed to supplement its exhibits, and cross-examine the DOI's witness. Thus, the Court cannot find that BridgeSpan's procedural due process rights were violated.[1]

D. Idaho Code section 41-6105(2)(c)(ii)

BridgeSpan argues that the Director's decision to exclude BridgeSpan from the individual market for five years is contrary to Idaho law because it penalizes BridgeSpan for its decision not to participate in the Exchange in violation of Idaho Code section 41-6105(2)(c)(ii). BridgeSpan's argument is without merit.

Idaho Code section 41-6105(2)(c)(ii) provides:

> Neither the exchange nor any agency of the state of Idaho shall require any person to use or participate in the exchange, nor have the authority to impose upon or collect from a person any penalty for failure or refusal to participate in the exchange or to purchase a health benefit plan or stand-alone dental plan.

[1] BridgeSpan also argues that the DOI's disparate treatment of Regence Blue Shield of Idaho ("RBSI") demonstrates that the DOI's legal analysis was arbitrary and capricious and that BridgeSpan's due process violations were prejudicial; however, BridgeSpan's arguments are not supported by any authority. BridgeSpan complains that it was not treated in a similar manner to RBSI because RBSI was allowed to negotiate changes to its 2018 offered plans through SERFF and BridgeSpan had to participate in a Show Cause Hearing; however, BridgeSpan has not presented any evidence or authority showing that the DOI was required to process BridgeSpan's plan negotiations through the SERFF program, or that somehow, the Show Cause Hearing did not present BridgeSpan with notice or a meaningful opportunity to be heard. Further, the record shows that the DOI filed two objections through the SERFF program prior to sending BridgeSpan notice of the Show Cause Hearing but did not receive satisfactory responses from BridgeSpan. Thus, the record indicates that both RBSI and BridgeSpan were given the opportunity to resolve the issue through SERFF.

I.C. § 41-6105. A plain reading of the statute provides that Idaho shall not require anyone to participate in the Exchange. However, the five year penalty statute at issue is not specific to the Exchange, rather it relates to Idaho's Guaranteed Renewability Statutes. Idaho Code section 41-5207(2) provides:

> An individual carrier that elects not to renew a health benefit plan under the provisions of subsection (1)(f) of this section shall be prohibited from writing new business in the individual market in this state for a period of five (5) years from the date of notice to the director.

I.C. § 41-5207(2). Despite BridgeSpan's repeated attempts to frame the issue as the DOI determining that BridgeSpan's exit from the Exchange was the only issue considered in its determination the BridgeSpan had elected not to renew its health benefit plans in 2018, that is simply not the case. The Decision and Order provides a reasoned analysis of how and why BridgeSpan's 2018 health plan offers were not the same plans BridgeSpan had offered in 2017. Thus, BridgeSpan's argument is without merit.

E. Costs on Appeal

Both parties request attorney fees pursuant to Idaho Code section 12-117, which provides:

> Unless otherwise provided by statute, in any proceeding involving as adverse parties a state agency or a political subdivision and a person, the state agency, political subdivision or the court hearing the proceeding, including on appeal, shall award the prevailing party reasonable attorney's fees, witness fees and other reasonable expenses, if it finds that the nonprevailing party acted without a reasonable basis in fact or law.

I.C. § 12-117(1). Based on the above, the DOI is the prevailing party on appeal. However, BridgeSpan did not act without a reasonable basis in fact or law. BridgeSpan presented an argument based on reasonable statutory interpretation of the federal uniform modification rules in good faith; thus, the Court does not award attorney fees.

CONCLUSION

The Director's Decision and Order is AFFIRMED.

Signed: 10/11/2018 02:12 PM

DATED this _____ day of _____, 2018.

Michael J. Reardon, District Judge

CERTIFICATE OF MAILING

The undersigned authority does hereby certify that on the 15th day of October 2018, I served one copy of the:

MEMORANDUM DECISION ON PETITION FOR JUDICIAL REVIEW

to each of the parties below as follows:

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Date: Signed: 10/15/2018 08:24 AM

By Beth Martin
Deputy Clerk

BEFORE THE DIRECTOR OF THE DEPARTMENT OF INSURANCE

STATE OF IDAHO

STATE OF IDAHO, DEPARTMENT OF INSURANCE, Complainant, vs. BRIDGESPAN HEALTH COMPANY, Certificate of Authority No. 4185 NAIC ID No. 95303 Respondent.	Docket No. 18-3347-17 **DECISION AND ORDER**

The above-entitled matter having come before the Director of the Idaho Department of Insurance (hereinafter "Director") and, having issued an Order to Show Cause, and in consideration of the pleadings, opening briefs, hearing before the Director, review of transcripts, and closing briefs on file herein, and in consideration of the premises, the Director does enter this Decision and Order.

COURSE OF PROCEEDINGS

The Idaho Department of Insurance (hereinafter "Department") filed a *Motion for an Order to Show Cause and Memorandum in Support Thereof* and *Affidavit of Weston Trexler*, on July 25, 2017. Upon

consideration of said Motion, the undersigned Director entered an *Order to Show Cause and Notice of Hearing*, setting the matter for hearing for 9:00 o'clock a.m., Friday August 25, 2017.

In response thereto, the Respondent, BridgeSpan Health Company (hereinafter "BridgeSpan"), filed its *BridgeSpan Health Company's Answer and Pre-Hearing Brief Re Order to Show Cause* (hereinafter "*Answer*") on August 15, 2017.

A hearing was held before the Director in Conference Room A of the Department's Boise, Idaho, offices, regarding the *Order to Show Cause* on four (4) separate dates: Friday, August 25, 2017; Thursday, September 7, 2017; Monday, September 18, 2017; and Monday, October 23, 2017. Attorney Wendy J. Olson appeared at hearing on behalf of BridgeSpan, with Hamilton Emery as BridgeSpan's client representative. Deputy Attorney General Judy L. Geier appeared at hearing on behalf of the Department, with Weston Trexler as the Department's client representative. At hearing, the parties called witnesses to provide testimony and introduced exhibits in support of their relative positions. Exhibits 1 through 24 were introduced by counsel for the Department and admitted into evidence. Exhibits A through O were introduced by counsel for BridgeSpan and admitted into evidence.

Upon completion of the hearing, the parties were granted additional time to concurrently file closing briefs. Both parties filed their respective closing briefs on November 13, 2017. BridgeSpan also filed its *Declaration of Wendy J. Olson* on the same date. The Director commends counsel for both parties on their steadfast and skillful representation of their respective clients, both at hearing and in briefing a particularly complex matter. The transcripts of the four (4) separate dates of hearing having been submitted and on file herein, and the record having been closed, this matter is now ready for consideration and decision.

ISSUE ON ORDER TO SHOW CAUSE

The issue before the Director, in accordance with the *Order to Show Cause* dated July 25, 2017, is whether BridgeSpan should be prohibited from writing new business in the individual market in the

state of Idaho for a period of five (5) years, pursuant to Section 41-5207(2), Idaho Code, for providing notice of its intent to not renew the individual health benefit plans that it offers on Your Health Idaho, the Idaho health insurance exchange (hereinafter "Exchange") as established under Title 41, Chapter 61, Idaho Code, which the Department contends equates to nonrenewal of all of BridgeSpan's health benefit plans delivered to individuals in the state of Idaho.

DISCUSSION

BridgeSpan Health Company was issued Certificate of Authority No. 4185 by the Department on January 18, 2013, in the disability line of insurance, including managed care. *Affidavit of Weston Trexler*, p. 2, para. 3. BridgeSpan is a subsidiary of Cambia Health Solutions, as is Regence BlueShield of Idaho (hereinafter "Regence").

In calendar years 2014 through 2017, BridgeSpan sold individual health benefit policies on the Idaho Exchange.[1] Tr. 30:5-12; 38:4; 56:3-6; 65:8-11. *See,* Section 41-6103(4), Idaho Code. BridgeSpan asserts that, for calendar years 2014 through 2017, any person who called BridgeSpan directly or walked into one of its offices could buy a BridgeSpan individual health benefit policy off-Exchange (*see,* Tr. 163:17-25). During 2014 through 2017, BridgeSpan had no off-Exchange enrollment. Tr. 88:15-89:8; 124:11-125:7.

On Friday, May 12, 2017, Scott Kreiling and Shad Priest, Regence's president and government relations officer, respectively, met with Tom Donovan, deputy director of the Idaho Department of Insurance, at the Department offices. Acting on behalf of Regence *and* BridgeSpan, Messrs. Kreiling and Priest informed the Department of BridgeSpan's intent to withdraw in calendar year 2018 from

[1] The Department has no authority "to require any person to use or participate in the exchange, nor ... authority to impose upon or collect from a person any penalty for failure or refusal to participate in the exchange[.]" Section 41-6105(2)(c)(ii), Idaho Code. In addition, nothing in the Idaho Health Insurance Exchange Act, namely Chapter 61, Title 41, Idaho Code, "shall be construed to preempt or supersede the authority of the director to regulate the business of insurance within this state pursuant to title 41, Idaho Code[.]" Section 41-6107, Idaho Code.

the individual market on the Exchange and move its business solely to the off-Exchange individual market. On the same date, BridgeSpan filed its 2018 policy forms with the Department, informing the Department that it intended to move off of the Exchange. Exhibit 1 and Tr. 178:24-179:3; 186:13-15; 291:19-25; 368:5-22; 369-370.

BridgeSpan states that it was motivated to move its 2018 individual health benefit plans off-Exchange due to, among other things: (1) a broken distribution channel or model, namely offering coverage through the Exchange; (2) substantial losses suffered by BridgeSpan in years 2014 through 2017, specifically, one million dollars in 2014 in that distribution channel, $1.6 million in losses in 2015, $7.9 million in 2016, and, year-to-date for 2017, $3.5 million as of August 25, 2017; (3) uncertainty of the future of the Exchange; (4) significant uncertainty at the federal level, including whether Congress will repeal the federal mandate or maintain and continue its enforcement, will provide funding for cost sharing reductions (hereinafter "CSR"), will reduce or eliminate funding for premium subsidies, or generally whether Congress will substantially change federal health benefit policy. Exhibits 3 and 4. Tr. 30-33; 42:6-25; 56:3-19; 62:19-63:8.

Under federal law, CSRs provide extra benefits to qualified beneficiaries on the Exchange and, in effect, improve benefits by reducing the amount of deductibles, coinsurance, co-payments, or out-of-pocket maximums to the consumer.[2] *See*, 42 U.S.C. § 18071. At hearing, CSRs were discussed at

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[2] *U.S. House of Representatives v. Burwell* ("*Burwell*"), 185 F.Supp. 3d 165, 171 (D.D.C. 2016). In the *Burwell* case, the U.S. House of Representatives sued the U.S. HHS, seeking an injunction to stop CSR payments on the basis that the U.S. Congress failed to appropriate funds for the CSRs. The Court granted the petitioner's injunction but stayed it pending appeal to the D.C. federal circuit court. That appeal is in abeyance. *See, Burwell,* 676 Fed. Appx. 1 (December 5, 2016). "To qualify for reduced cost sharing, an individual must enroll in a qualified health plan and have a household income that "exceeds 100 percent but does not exceed 400 percent of the poverty line for a family of the size involved." 42 U.S.C. § 18071(b)(2). Individuals with income between 100 and 250 percent of the poverty line qualify for an "additional reduction." *Id.* § 18071(c)(2). Eligibility for premium tax credits under Section 1401 is also a prerequisite to receiving **cost-sharing reductions** under Section 1402. *See* ACA § 1402(f)(2) ('No cost-sharing reduction shall be allowed under this section ... unless ... a credit is allowed to the insured ... under section 36B of [the Internal Revenue] Code.')." *Burwell,* 185 F.Supp. 3d at 171. The health carriers are supposed to get their money back, after notifying the Secretary of the United States Department of Health and Human Services. *Id.* The issue in the Burwell case did not involve the premium tax credit that had been earlier authorized, but "whether Congress appropriated the billions of dollars that the Secretaries have spent since January 2014 on Section 1402 [42 U.S.C. § 18071] reimbursements." *Burwell,* 185 F.Supp.3d at 174.

length, including whether the current federal Administration would cease CSR payments to health carriers, the impact of such on current federal health policy, and the fact that, absent such subsidies, the amount of premium received by the health carrier would be reduced, which could increase health insurance rates. Tr. 300:14-18; 400:19-401-22.

On May 24, 2017, BridgeSpan notified its producers that BridgeSpan had filed its 2018 individual health plans with the Department, and that it would continue to offer individual plans off-Exchange but not through the Exchange. Exhibit 3. Tr. 170:18-171:4.

Following the Department's review of BridgeSpan's 2018 plans filed with the Department on May 12, 2017, the Department's counsel, by letter dated June 14, 2017, informed BridgeSpan that its proposed actions were in violation of Idaho's guaranteed renewability law, section 41-5207, Idaho Code, and formally disapproved BridgeSpan's 2018 filing effective June 29, 2017. Exhibit 7. *See,* Tr. 275:4-20.

On the next day, June 15, 2017, BridgeSpan sent a letter of notification to its Exchange members alerting them that BridgeSpan would cease offering its individual health insurance plans on the Exchange effective January 1, 2018, and that BridgeSpan intended to continue to offer individual health insurance plans off-Exchange commencing in 2018. Exhibit A. *See,* Tr. 165:14-166:25.

On June 16, 2017, BridgeSpan responded to the Department's June 14, 2017, letter disapproving the 2018 filings, and notified the Department of BridgeSpan's intent to "continue to offer at least one health benefit plan to individuals in Idaho on an . . . off-Exchange basis." Exhibit 9.

Later that month, on June 28, 2017, BridgeSpan sent a follow-up letter to its members, advising them that the Department disagreed with BridgeSpan's position that it could offer individual health insurance plans outside the Exchange, "which BridgeSpan believes it may do under Idaho law. The [Department] disagrees, and believes BridgeSpan must exit the individual market entirely." Exhibit G. *See,* Tr. 168; 169:1-18.

On June 29, 2017, through counsel, BridgeSpan requested a waiver from the Director, permitting BridgeSpan to offer the same or similar qualified health plans off-Exchange in 2018 as it did in 2017, without considering it a discontinuation of the on-Exchange plans. Exhibit 11. On June 30, 2017, the request for a waiver was declined. Exhibit 14.

In this case, the Department alleges that BridgeSpan's 2018 filings are in effect a nonrenewal of all of BridgeSpan's individual health benefit plans and therefore subject BridgeSpan to the penalties stated under section 41-5207(2), Idaho Code, effectively barring BridgeSpan from writing new business in the individual market in the state of Idaho for a period of five years. The relevant portion of section 41-5207, Idaho Code, provides as follows:

> (1) A health benefit plan subject to the provisions of this chapter [52] shall be renewable with respect to the individual or dependents, at the option of the individual, except in any of the following cases:
>
> . . . .
>
> (e) The individual carrier elects, at the time of coverage renewal, to discontinue offering a particular health benefit plan delivered or issued for delivery to individuals in this state. Unless otherwise authorized in advance by the department of insurance, a carrier may discontinue a product only after the product has been in use for at least thirty-six (36) consecutive months, provided the carrier may not discontinue more than fifteen percent (15%) of its total number of individuals and dependents in all lines of business regulated by this chapter in a twelve (12) month period. The carrier shall:
>
> (i) Provide advance written or electronic notice of its decision under this paragraph to the director;
>
> (ii) Provide notice of the discontinuation to all affected individuals at least ninety (90) calendar days prior to the date the particular health benefit plan will be discontinued by the carrier, provided that notice to the director under the provisions of this paragraph shall be provided at least fourteen (14) calendar days prior to the notice to the affected individuals;
>
> (iii) Offer to each affected individual, on a guaranteed issue basis, the option to purchase all other health benefit plans currently being offered by the carrier to individuals in this state;
>
> (iv) Act uniformly without regard to any health status-related factor of an affected individual or dependent of an affected individual who may become eligible for the coverage; and
>
> (v) Offer the new products at rates that comply with section 41-5206(1)(b), Idaho Code.
>
> (f) The individual carrier elects to nonrenew all of its health benefit plans delivered or issued for delivery to individuals in this state. In such a case the carrier shall:
>
> (i) Provide advance notice of its decision under this paragraph to the

director; and

(ii) Provide notice of the decision not to renew coverage to all affected individuals and to the director at least one hundred eighty (180) calendar days prior to the nonrenewal of any health benefit plans by the carrier. Notice to the director under the provisions of this paragraph shall be provided at least three (3) working days prior to the notice to the affected individuals[.] . . .

(2) An individual carrier that elects not to renew a health benefit plan under the provisions of subsection (1)(f) of this section shall be prohibited from writing new business in the individual market in this state for a period of five (5) years from the date of notice to the director.

(3) In the case of an individual carrier doing business in one (1) established geographic service area of the state, the rules set forth in this subsection shall apply only to the carrier's operations in that services area.

Section 41-5207, Idaho Code (underscore here).

The stated purpose of Chapter 52, Title 41, Idaho Code, is to "promote the availability of health insurance coverage to persons not covered by employment based insurance regardless of their health status or claims experience . . . to establish rules regarding renewability of coverage, . . . and to improve the overall fairness and efficiency of the individual health insurance market." Section 41-5202, Idaho Code (underscore here).[3] Unless one of the exceptions applies, under section 41-5207, Idaho Code, an individual health benefit plan is renewable at the option of the individual. Section 41-5207(1), Idaho Code.

Subsection (e) of section 41-5207(1), Idaho Code, allows a partial withdrawal, subject to certain limitations, where a health carrier (or "issuer" or "insurer") elects to discontinue a particular individual health benefit plan.

Subsection (f) of the statute provides a process and consequences if an individual health carrier elects to nonrenew all of its health benefits plans in the state of Idaho. Such process requires advance notice to the Director and 180 days' advance notice to all policyholders, with notice to be provided to the Director at least three working days before notice to the policyholders. *See,* section 41-5207(1)(f),

[3] The Idaho Insurance Code contains similar "guaranteed renewability" coverage applicable to group and blanket disability insurance (*see,* section 41-2223(1)(h), Idaho Code) and small employer health insurance coverage (*see,* section 41-4707(1)(h), Idaho Code).

Idaho Code. If the health carrier elects to nonrenew all such plans in the state of Idaho, the carrier is barred from writing new individual market coverage for five (5) years after the date of notice to the Director. *See*, section 41-5207(2), Idaho Code. The same rules apply where an individual health carrier is doing business in one geographic service area. *See,* section 41-5207(3), Idaho Code.

In answer to the Department's claim, BridgeSpan denies it is subject to the five-year bar in section 41-5207(2), Idaho Code, and answers that BridgeSpan is committed to the individual health benefit market in Idaho, that BridgeSpan's proposed move from the Exchange to the off-Exchange individual health insurance market is permissible under Idaho law, and that BridgeSpan is compliant with the federal guaranteed renewability provisions under the Affordable Care Act (hereinafter "ACA"). *See, Answer*, pp. 1-2. In response to the *Order to Show Cause*, BridgeSpan asks the Director to find that BridgeSpan will stay in the Idaho individual health insurance market and intends to renew policies up to 6,000 members on an off-Exchange basis; that federal law in effect preempts Idaho's narrow guaranteed renewability statutes; and that, even if not preempted, the Director has the authority to grant BridgeSpan a waiver from section 41-5207, Idaho Code. *See, Answer*, p. 2.

I. Availability of BridgeSpan's individual health plans off-Exchange for year 2017.

BridgeSpan has never had any off-Exchange enrollment. Tr. 88:5-89:8. With regard to offering the consumer on- and off-Exchange products, BridgeSpan's witness testified that BridgeSpan in 2017 was legally required "to make those plans both available with on and off exchange as part of guaranteed renewability. And if a consumer called and requested a BridgeSpan plan off exchange we would offer it." Tr. 82:14-24. Yet, for years 2014 through 2017, BridgeSpan failed to enroll a single person off-Exchange. In fact, the Department's witness testified that, when he tried to obtain coverage off-Exchange, he was told that BridgeSpan does not offer plans off-Exchange. Tr. 302:9-25; 303, 304:1-6. *See, also,* Exhibit 2. Moreover, BridgeSpan failed to file with the Department, as legally required, the individual health benefit policy forms or required applications to be used off-Exchange. Tr. 279:7-

19; 282:18-283:11. In other words, if BridgeSpan had sold plans off-Exchange during those years, BridgeSpan would have been in violation of Idaho law that mandates the filing of policy forms and applications with the Department. *See,* section 41-1812, Idaho Code. Therefore, the Director finds any argument that BridgeSpan had an off-Exchange presence or offered individual health benefit plans for sale off-Exchange to be unpersuasive.

II. Do BridgeSpan's 2018 filings constitute an election to nonrenew all of its individual health benefit plans as contemplated by section 41-5207(1)(f), Idaho Code?

The primary question under section 41-5207(1)(f), Idaho Code, is whether, by its 2018 filings, BridgeSpan has elected to nonrenew all of its health benefit plans delivered or issued for delivery to individuals in the state of Idaho. From its initial 2013 year of operation through the end of 2017, BridgeSpan sold its products strictly on the Exchange. It was BridgeSpan's strategy to market its individual products on the Exchange in the states of Washington, Idaho, Oregon and Utah. Tr. 161:9-25; 162:17-21. In 2017, BridgeSpan marketed 33 plans on the Idaho Exchange. For 2018, BridgeSpan intends to offer no plans on the Exchange and to instead offer four plans entirely off-Exchange, effectively nonrenewing at least 29 of its 33 plans. BridgeSpan claims the four 2018 plans are essentially the same as four of its 2017 Exchange plans. The 2018 plans are identified as:

EPO Silver HDHP 3000	HIOS No.: 59765ID0090001
EPO Bronze HDHP 6000	HIOS No.: 59765ID0090002
EPO Silver Essential 4000	HIOS No.: 59765ID0090004
EPO Bronze Essential 7150	HIOS No.: 59765ID0090005

Exhibits D, E, and 5. If the Director finds that the four 2018 plans as filed by BridgeSpan are not the same as the 2017 plans, BridgeSpan will be prohibited from writing new business in the individual market in Idaho for a period of five years, pursuant to section 41-5207(2), Idaho Code.

There are notable differences between BridgeSpan's Exchange policy forms filed for calendar year 2017 and the off-Exchange policy forms submitted to the Department for filing for calendar year 2018. *See,* Exhibit 12. Tr. 284:14-285:9. During its review of the policies in question, the Department

requested of BridgeSpan a redline version of the 2018 policies, to include "any and all changes from the 2017 wording to the 2018 wording." Exhibit 17, p. 3. *See, also,* Tr. 610:10-15. In BridgeSpan's initial response, personnel acting on behalf of BridgeSpan stated that the 2018 filings are new plans and no comparison between the 2017 and 2018 forms could be completed. Exhibit 17, pp. 2-3. However, redline versions were eventually submitted upon repeated requests. Tr. 286:19-25; 287:1-7; 297:1-4; 339:1-7. *See, also,* Exhibits 17, 18 & 19. BridgeSpan provided a summary of changes to the plans that included:

(1) a change to the provider network to a Medical Neighborhood network;

(2) a change to the network name to add the term "EPO" ["exclusive provider organization"] to the front of the plan name (*see,* Exhibit E under "Plan Marketing Name");

(3) an increase of the out-of-network co-insurance for consumers from 50% in 2017 to 90% in 2018;

(4) some "minor" changes to accommodate IRS changes;

(5) a raise in the maximum out-of-pocket expense;

(6) minor changes in the pharmacy cost shares; and

(7) a change from the 2017 plan types identified as PPOs or "preferred provider organization" to an EPO plan type for 2018. *See,* Exhibits D, E, and F. Tr. 84:3-85:17.

Many of the changes summarized by BridgeSpan and identified above are inconsequential, and the Director concludes, with the exceptions enumerated below, that such alterations do not cause a change in the plan for 2018. However, for the changes identified in numbers (1), (2), (3) and (7), such must be reviewed to measure the extent of change, if any, and its impact on the question of whether a new plan is being offered for 2018.

A. Change from Preferred Network to Medical Neighborhood Network

The initial alteration in number (1) above is the change in network, from a preferred network to a "Medical Neighborhood" network. BridgeSpan asserts that, although the networks are distinct, the two networks for 2017 and 2018 are essentially PPO networks, which include a health carrier contracting with providers for, among other things, reimbursement rates and provider participation. BridgeSpan states that its "networks in 2017 had in and out of network benefits. Our network in 2017 did not require you to select a primary care physician. Our network in 2017 didn't require you to have a referral to see a specialist. Or to go see a hospital in any way. And our products in 2018 have the same features." Tr. 172:17-25; 174:106.

BridgeSpan maintains there were no "gatekeeper" referral requirements in 2017 and that, for 2018, the Medical Neighborhood network likewise has no "gatekeeper" requirement, as there are no referral requirements in the network for primary care physicians (hereinafter "PCPs"), specialists, or hospitals. Tr. 173:7-16. The main distinction between the 2017 and 2018 networks is that, for the 2018 Medical Neighborhood network, each policyholder would have to select a new provider group within the network. Tr. 353:12-18. In the 2017 preferred network, the number of PCPs was 3,085, compared with 1,097 PCPs in the 2018 Medical Neighborhood network. Tr. III, p. 489.

Despite BridgeSpan's assertion that the networks are the same or substantially similar, to the policyholder there exists a substantial reduction of nearly two-thirds (2/3) of the PCPs from which to choose, there is a marked difference between the preferred network and the Medical Neighborhood network.

B. Increase in Out-of-Network Maximum from 50% to 90%

As to number (3) above, the out-of-network co-insurance faced by the consumer went from 50% in 2017 to 90% in 2018—a substantial increase to the consumer. It may likely be the highest burden on the consumer permitted under Idaho law. There was testimony that the change in the out-

of-network co-insurance had no actuarial significance (Tr. 155:16-23; 535:11-250); yet it is curious that BridgeSpan made the significant change where there was "no" actuarial significance. Nevertheless, the increased out-of-pocket cost to the consumer is a substantial change to the plans for 2018.

C. Change from PPO Plan Type to EPO Plan Type

With regard to number (7) above, BridgeSpan facially altered the plan types for 2017 and 2018. The 2017 plan types were identified as a PPO or "preferred provider organization." In its 2018 filings, BridgeSpan identified its plan filings as an EPO plan type. At the federal HealthCare.gov website, the Centers for Medicare and Medicaid Services ("CMS"), defines a PPO plan type as one where the policyholder pays less if the policyholder uses the medical providers in the plan's network and where the policyholder can use doctors, hospitals, and providers outside of the network without a referral. The website defines an EPO as a type of managed care plan where medical services are covered, except in an emergency, only if the policyholder uses doctors, specialists, or hospitals in the plan's network. *See,* https://www.healthcare.gov/choose-a-plan/plan-types/. *See, also,* Tr. 87:1-13; 94:7-14; 99: 10-15; 104: 6-9; 107:18-25.

Under Idaho law, a managed care plan is required to pay all or a portion of the cost of out-of-network services. *See,* section 41-3905(3), Idaho Code. Because managed care plans must pay a portion of out-of-network costs, and because of the exclusivity of an EPO, Idaho law does not recognize an EPO-type arrangement. Tr. 87:16-25.

BridgeSpan maintains that the *name of the plan type* was changed for 2018 but that the plans in question are in fact PPO plans. "It is not a managed care network, so members are able to schedule appointments with any provider within the network." The insurer does not pick the PCP, referrals are not required to see specialists and hospitals. Tr. 188:12-15; 189:1-3.

A health carrier may file a "nonmanaged care plan . . . if the health plan reimburses providers solely on a fee for service basis and does not require the selection of a primary care provider." Section

41-3903(15), Idaho Code. Under the 2018 filings, the policyholder must pick a "Medical Neighborhood" of providers, but the policyholder is able to choose their PCP from the network.

BridgeSpan used the term "EPO" to describe the 2018 plan type and the plan marketing name. *See,* Exhibit E. In its responses to the 2018 BridgeSpan filings, BridgeSpan claims the Department did not expressly object to BridgeSpan's use of the term EPO plan type. Tr. 474:22-475:5. Those same filings are in question here and were denied by the Department. Nevertheless, BridgeSpan's use of the term "EPO" contrary to how the term is commonly used—*i.e.,* commonly meaning the plan *has no out of network benefits*—is troubling and questionable, as use of the term will cause additional confusion for consumers. The use of the term EPO, especially in concert with changing networks and changing co-insurance, would have a chilling effect on consumers purchasing or agents marketing BridgeSpan plans.

D. On-Exchange versus off-Exchange renewal availability and distinctions.

Finally, as to the issue of section 41-5207(1)(f), there are further distinctions between plans marketed on- and off-Exchange to be considered. On the Exchange, the cost of purchasing a qualified health plan may be subsidized either by the "advance premium tax credit" (hereinafter "APTC") and the CSR program as described above. The APTC is a tax credit an individual may take in advance to offset his or her monthly health insurance premium. These subsidies are not available off the Exchange. As of May 2017, BridgeSpan had 19,292 members, of which 12,767 were subsidized under the CSR program. Tr. 72:18-20; 73:8-11. Of the total membership, BridgeSpan claims 5,803 members do not receive a CSR subsidy, and a total of approximately 1,900 of those 5,803 members do not receive the APTC subsidy. Tr. 118:15-22; 121:11-21. BridgeSpan claimed at hearing that 5,803 members would be able to renew their plans in 2018 off the Exchange. Tr. 75:4-12. The *Declaration of Wendy J. Olson*, filed concurrently with BridgeSpan's closing brief on November 13, 2017, states at paragraph 3 that "BridgeSpan forecast that it would have 800 members in its 2018 ... offering renewal

and plans solely off of the exchange." (Underscore here.) The figures and the testimony are difficult to reconcile, yet it appears to the Director that there are very few Idahoans who would follow BridgeSpan to off-Exchange plans, especially given all the other changes. Based on BridgeSpan's own admittance, at best approximately 800 members, to as many as 1,900 BridgeSpan members that did not receive CSR and/or APTC subsidies in 2017, could foreseeably access BridgeSpan's off-Exchange plans in 2018. Even if true, the 2018 BridgeSpan filings are new plans and cannot be offered on a guaranteed renewal basis off-Exchange. Further, based on federal exchange requirements, these members would be "cross-walked" or mapped to other on-Exchange plans.

Based on the foregoing analysis and on the requirements of section 41-5207(1)(f), Idaho Code, the Director concludes that BridgeSpan, in filing its 2018 plans, gave de facto notice of its election to withdraw from the individual health insurance market in Idaho. As such, the Director further concludes that BridgeSpan is subject to the penalties undersection 41-5207(2), Idaho Code, prohibiting BridgeSpan from writing new business in the individual market in the state of Idaho for a period of five years from the date of such notice to the Director, namely May 12, 2017.

III. Do the federal guaranteed renewability and uniform modification rules preempt Idaho's guaranteed renewability statute?

Chapter 52, Title 41, Idaho Code, recognizes the state and federal role in governance of individual health benefit plan coverage: "[t]o the extent permitted by federal law, the provisions of [chapter 52, title 41, Idaho Code] shall apply to any health benefit plan delivered or issued for delivery in the state of Idaho that provides coverage to eligible individuals and their dependents ...." Section 41-5204(1), Idaho Code (underscore here).

With regard to individual plans, the federal guaranteed renewability statute provides:

> (a) In general. Except as provided in this section, a health insurance issuer that provides individual health insurance coverage to an individual shall renew or continue in force such coverage at the option of the individual.
> (b) General exceptions. A health insurance issuer may nonrenew or discontinue health insurance coverage of an individual in the individual market based only on one or more

of the following:

. . . .

(3) Termination of Plan. The issuer is ceasing to offer coverage in the individual market in accordance with subsection (c) of this section and applicable State law.

. . . .

(c) Requirements for uniform termination of coverage.

(1) Particular type of coverage not offered. In any case in which an issuer decides to discontinue offering a particular type of health insurance coverage offered in the individual market, coverage of such type may be discontinued by the issuer only if—

(A) the issuer provides notice to each covered individual provided coverage of this type in such market of such discontinuation at least 90 days prior to the date of the discontinuation of such coverage;

(B) the issuer offers to each individual in the individual market provided coverage of this type, the option to purchase any other individual health insurance coverage currently being offered by the issuer for individuals in such market; and

(C) in exercising the option to discontinue coverage of this type and in offering the option of coverage under subparagraph (B), the issuer acts uniformly without regard to any health status-related factor of enrolled individuals or individuals who may become eligible for such coverage.

(2) Discontinuance of all coverage

(A) In general. Subject to subparagraph (C), in any case in which a health insurance issuer elects to discontinue offering all health insurance coverage in the individual market in a State, health insurance coverage may be discontinued by the issuer only if—

(i) the issuer provides notice to the applicable State authority and to each individual of such discontinuation at least 180 days prior to the date of the expiration of such coverage, and

(ii) all health insurance issued or delivered for issuance in the State in such market are discontinued and coverage under such health insurance coverage in such market is not renewed.

(B) Prohibition on market reentry. In the case of a discontinuation under subparagraph (A) in the individual market, the issuer may not provide for the issuance of any health insurance coverage in the market and State involved during the 5-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed.

(d) Exception for uniform modification of coverage. At the time of coverage renewal, a health insurance issuer may modify the health insurance coverage for a policy form offered to individuals in the individual market so long as such modification is consistent with State law and effective on a uniform basis among all individuals with that policy form. . . .

42 U.S.C. § 300gg-42 (*See, also,* 42 U.S.C. § 300gg-2) (underscore here). The foregoing federal statute is substantially similar to section 41-5207, Idaho Code, and requires health carriers to guarantee the

renewability of coverage at the option of the individual unless an exception applies. 79 F.R. 30242. One notable difference between Idaho law and the federal guaranteed renewability statute, not provided for under Idaho law, is identified as the "exception for uniform modification of coverage" (hereinafter "EUMC"). *See above,* 42 U.S.C. § 300gg-42(d). If a health carrier makes modifications to an existing individual health insurance policy form that "is consistent with State law and effective on a uniform basis among all individuals with that policy form," the modifications will not be considered a discontinuation of an existing product. *Id.*

The U.S. Department of Health and Human Services (hereinafter "HHS") promulgated rules, namely 45 C.F.R. § 147.106, that establish "criteria for determining when modifications made by an issuer to the health insurance coverage for a product would and would not constitute the discontinuation of an existing product and the creation of a new product." 79 F.R. 30242. The EUMC rule provides:

> (e) *Exception for uniform modification of coverage.*
> (1) Only at the time of coverage renewal may issuers modify the health insurance coverage for a product offered to a group health plan or an individual, as applicable, in the following:
>
> (i) Large group market.
>
> (ii) Small group market if, for coverage available in this market (other than only through one or more bona fide associations), the modification is consistent with State law and is effective uniformly among group health plans with that product.
>
> (iii) Individual market if the modification is consistent with State law and is effective uniformly for all individuals with that product.
>
> (2) For purposes of paragraphs (e)(1)(ii) and (iii) of this section, modifications made uniformly and solely pursuant to applicable Federal or State requirements are considered a uniform modification of coverage if:
>
> (i) The modification is made within a reasonable time period after the imposition or modification of the Federal or State requirement; and
>
> (ii) The modification is directly related to the imposition or modification of the Federal or State requirement.
>
> (3) Other types of modifications made uniformly are considered a uniform modification of coverage if the health insurance coverage for the product in the individual or small group market meets all of the following criteria:
>
> (i) The product is offered by the same health insurance issuer (within the meaning of section 2791(b)(2) of the PHS Act), or if the issuer is a member of a controlled group (as described in paragraph (d)(4) of this section), any other

health insurance issuer that is a member of such controlled group);
(ii) The product is offered as the same product network type (for example, health maintenance organization, preferred provider organization, exclusive provider organization, point of service, or indemnity);
(iii) The product continues to cover at least a majority of the same service area;
(iv) Within the product, each plan has the same cost-sharing structure as before the modification, except for any variation in cost sharing solely related to changes in cost and utilization of medical care, or to maintain the same metal tier level described in sections 1302(d) and (e) of the Affordable Care Act; and
(v) The product provides the same covered benefits, except for any changes in benefits that cumulatively impact the plan-adjusted index rate (as described in § 156.80(d)(2) of this subchapter) for any plan within the product within an allowable variation of ±2 percentage points (not including changes pursuant to applicable Federal or State requirements).
(4) A State may only broaden the standards in paragraphs (e)(3)(iii) and (iv) of this section.

45 C.F.R. § 147.106(e) (underscore here).

The above federal guaranteed renewability law and its accompanying rules are designed to work in harmony with state law and requirements. *See*, section 41-5204, Idaho Code (cited *supra*); 42 U.S.C. § 300gg-2; and 45 C.F.R. § 147.106(e). The preemption of state law by federal law is not to be inferred or presumed:

> Federal law may preempt state law in one of two ways. First, if Congress has shown the intent to occupy a given field, any state incursion into that field is preempted by federal law. Second, even if the field is not preempted, if state law conflicts with federal law, it is preempted to the extent of the conflict. In order to find that a state law has been preempted, [it must be determined] that the law "stands as an obstacle to the full accomplishment and execution of the full purposes and objectives of Congress." Essentially, [it must be found] that a state law is directly contrary to the congressional intent behind a federal statute before state law will be preempted.

Idaho DHW v. McCormick, 153 Idaho 468, 471, 283 P.3d 785, 788 (2012) (quoting *Christian v. Mason*, 148 Idaho 149, 152, 219 P.3d 473, 476 (2009)).

Federal law also states that "[n]othing in this title [of the ACA] shall be construed to preempt any State law that does not prevent the application of the provisions of this title." 42 U.S.C. § 18041(d). The state of Idaho has the flexibility to apply additional criteria that do not prevent the application of

the ACA. With regard to the EUMC and, in particular, subsections 45 C.F.R. § 147.106(e)(3)(iii) and (iv), the state may broaden the scope of uniform modification. However, a state standard that is narrower or prohibits a health carrier from uniformly modifying coverage under 45 C.F.R. § 147.106 may be preempted. 79 F.R. 30248, 30252. *See, also,* 45 C.F.R. § 147.106(e)(4), and 42 U.S.C. § 10841(d).

The federal rule provides that a modification made by a health carrier pursuant to a requirement of applicable federal or state law is a modification of the same product. 79 F.R. 30248. However, as in the instant case, where a health carrier makes a modification not mandated by federal or state law, such change would be considered an EUMC only if the product meets the criteria identified above under 45 C.F.R. § 147.106(e)(3). *See,* 79 F.R. 30248.

The issue then is whether BridgeSpan's 2018 individual health benefit plans are compliant with the EUMC rule, thereby conceding to BridgeSpan a "safe harbor" from the guaranteed renewability of coverage mandate under federal law. *See,* 45 C.F.R. § 147.106(e)(3).

Of the five criteria in 45 C.F.R. § 147.106(e)(3) noted above, the issues involving romanettes (i) (product offered by the same health insurance issuer); (iii) (product covers at least a majority of same service area); and, (v) (product covers the same covered benefits) are undisputed. *See,* Tr. 137:6-12; 138:12-24; 141:10-25. *See, also,* Department's *Closing Argument,* p. 23; and, *BridgeSpan Health Company's Closing Brief,* p. 15. The two criteria in dispute are romanettes (ii) and (iv) of 45 C.F.R. § 147.106(e)(3): respectively, whether the product(s) offered by BridgeSpan for 2018 are of the same product network type and whether each plan has the same cost-sharing structure.

A. Same Product Network Type

A review of the product network type will be examined at the product level. A "product" is defined by federal rules as

> [a] discrete package of health insurance coverage benefits that are offered using a particular product network type (such as health maintenance organization [HMO], preferred provider organization [PPO], exclusive provider organization [EPO], point of service, or indemnity) within a service area.

45 C.F.R. § 144.103 (underscore here).

In 2017, BridgeSpan offered a product identified as HIOS Product No. 597ID009 with five plans, identified as follows:

59765ID0090001	Silver HDHP 3000
59765ID0090002	Bronze HDHP 6000
59765ID0090003	Gold Essential 1200
59765ID0090004	Silver Essential 4000
59765ID0090005	EPO Bronze Essential 7150

Exhibit F. All five plans are identified by BridgeSpan as a "preferred provider organization" type of plan. *Id.* BridgeSpan claims all five plans were available off and on the Exchange; albeit for years 2014 through 2017, BridgeSpan failed to file any off-Exchange individual health benefit policy forms or applications with the Department as required. *Id. See,* Tr. 279:7-19; 282:18-283:11. Under Idaho law, no policy forms or applications may be delivered or issued for delivery in the state of Idaho, unless such forms or applications are first filed with the Department. Section 41-1812(1), Idaho Code.

In its 2018 filings, the four plans offered by BridgeSpan—and asserted by BridgeSpan to be the same as four of the above-listed 2017 plans (with one exception, namely the "Gold Essential 1200)—are identified in title as "exclusive provider organization" ("EPO") plans. Exhibit E. As previously stated above, the federal website, HealthCare.gov identifies an EPO as a type of managed care plan where, except in cases of emergency, services are covered only if an insured uses the providers, specialists, and hospitals in the plan's network. A true EPO has no out-of-network benefit. Tr. 100:6-10. Idaho recognizes three product network types, as provided under Idaho Code, including an "indemnity" type, where there is no provider network, a preferred provider organization or PPO, and a managed care organization. Tr. 356:1-7. Idaho law requires managed care plans to cover all or a portion of the cost of out of network services. *See,* section 41-3905(3), Idaho Code. Tr. 87:16-25.

BridgeSpan's 2017 filings show the plans to be a PPO product network type. Exhibit F. In its 2018 filings, BridgeSpan identified its proposed plans as an EPO product network type. *See,*

Exhibits C, D. and E. Yet, at hearing, BridgeSpan identified the 2018 filings as a PPO product network type. Tr. 123:7-30; 137:17-18. BridgeSpan argues that identifying the various types of plans, including PPO and EPO, is a challenge under Idaho law. Tr. 107:18-25; 108:21-25; 109:1-4; 110:1-8. It is partly that muddled interpretation and lack of clarity, as revealed in the record surrounding its 2018 filings, which leads the Director to conclude that the BridgeSpan 2018 filings are not the same product network type as the 2017 plans.

The 2018 filings include a change in out-of-network cost-sharing coinsurance from 50% for 2017 to 90% for 2018. In addition, for 2018, BridgeSpan changed its network from a "preferred network" to a "Medical Neighborhood" network. Tr. 90: 24-25; 91:1-4. This change added a subnetwork or selection feature. Tr. 84: 9-16.

The Director finds there is a significant change in the product network type, as the 2018 plans more closely resemble a managed care product type than any other product type contemplated under Idaho law. Therefore, BridgeSpan's 2018 filings fail to satisfy romanette (ii) of the EUMC at 45 C.F.R. 147.106(e)(3).

B. Same Cost-Sharing Structure.

The cost-sharing structure consists of the deductible, coinsurance, co-payments, and out-of-pocket maximums and, when taken together, is a mechanism to allocate the cost of the medical service between the insurer and the consumer. *Burwell,* 185 F.Supp. 3d at 171. *See,* Tr. 141:1-9. While the federal renewability statute has been interpreted at the product level, "in accordance with [HHS] definitions of 'product' and 'plan,' [HHS] note[s] that cost-sharing applies at the plan level." 79 F.R. 30251. The term "plan" means:

> With respect to a product, the pairing of the health insurance coverage benefits under the product with the particular cost-sharing structure, provider network, and service area. The product comprises all plans offered with those characteristics and the combination of the service areas for all plans offered within a product constitutes the total service area of the product.

45 C.F.R. § 144.103 (underscore here). To be the same product, each plan within the product must have the same cost-sharing structure as before the modification, "except for any variation in cost sharing solely related to change in cost and utilization of medical care, or to maintain the same metal tier level . . .." 45 C.F.R. § 147.106(e)(3)(iv). In the instant case, in its 2018 filings, BridgeSpan modified the cost-sharing structure by significantly increasing the out-of-pocket percentage borne by the insured for out-of-network providers from 50% to 90%.[4] Exhibit D. Tr. 116-117; 150:19-151:1. BridgeSpan claims this modification in the out-of-network cost-sharing structure lacks actuarial significance. Tr. 145:9-18. The Department's witness acknowledged that the actuarial value of a plan is not impacted by out-of-network benefits. Tr. 535:16-25. The overall purpose of the modification appears to be to cover additional costs or to discourage enrollment. The Department notes, however, that the modification is a strong incentive for the healthcare consumer to stay in-network. The Department also claims the modification is not an inflationary necessity, but a move toward an exclusive provider organization that has no out-of-network benefits. Tr. 262:4-25.

With regard to the issue of cost-sharing structure modifications, CMS, the responsible oversight agency at the federal level, stated that CMS will defer to a state's "reasonable interpretation" of 45 C.F.R. § 147.106(e)(3)(iv). *See,* CMS Bulletin, dated June 15, 2015, "Uniform Modification and Plan/Product Withdrawal FAQ," p. 3. The increase in percentage from 50% to 90% out-of-network cost-sharing coinsurance is substantial and unreasonable. *See,* 79 F.R. 30251. In addition, BridgeSpan increased the out-of-pocket maximums in all four of its 2018 plans. Therefore, the Director finds that the cost-sharing structure in BridgeSpan's 2018 filings is not the same as provided in its pre-2018 filings as defined under the term "Plan" in 45 C.F.R. § 144.103, in accord with 45 C.F.R. § 147.106. In sum, BridgeSpan's 2018 filings fail to satisfy romanette (iv) of the EUMC at 45 C.F.R. 147.106(e)(3).

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[4] Except for the 4th Plan, identified with HIOS No. 59765ID009, which did not change the "out of network coinsurance" *See,* Tr.361: 2-11. *See,* Exhibit D.

FINAL ORDER

The controversy discussed at length herein is grounded on Idaho's guaranteed renewability statute and, in particular, Chapter 52, Title 41, Idaho Code. The purpose of the guaranteed renewability statute is to prevent speculation by health carriers and to maintain stability and predictability in the individual marketplace in Idaho. After the ACA was made law, health carriers sought a place in Idaho's Exchange and the individual health marketplace. BridgeSpan's choice to market and sell individual health insurance products and plans strictly on the Exchange demonstrated an aggressive strategy and an understanding of the risk involved. In carrying out that strategy, BridgeSpan solicited customers, collected premiums, and paid claims, yet ultimately suffered substantial losses. In 2017, BridgeSpan sought to completely withdraw from the Exchange and to offer some significantly modified version of its plans off-Exchange, in an apparent effort to avoid market risk, minimize its losses, and avoid paying future claims under guaranteed renewable coverage. BridgeSpan's efforts resulted in a violation of state law, namely section 41-5207, Idaho Code.

If BridgeSpan's approach were upheld in the instant case, it could negatively impact Idaho's individual health insurance market both on- and off-Exchange, giving incentive to health carriers to enter the marketplace and assume risk that is initially low and to then withdraw, shifting that risk to another carrier when the risk matures and becomes less profitable. This is the reason why the guaranteed renewability statute exists: to prevent insurer speculation and to avoid a volatile market. It also protects consumers against market fluidity and instability, fickle carrier loyalty, and the constant shifting of risk from one carrier to another.

The Director has concluded that BridgeSpan is subject to the five (5) year penalty as provided in section 41-5207(2), Idaho Code; however, the Director reserves the right to suspend such penalty at a future date if BridgeSpan, upon application, satisfactorily demonstrates its willingness to

participate in the insurance marketplace, whether on- or off-Exchange, to commit to the consumers of the state of Idaho, and to comply with the provisions of the Idaho Insurance Code, inclusive of Title 41, Idaho Code.

NOW, THEREFORE, in furtherance of the foregoing findings of fact and conclusions of law, and in consideration of the premises, the Director does enter the following Order.

IT IS HEREBY ORDERED that the Respondent BRIDGESPAN HEALTH COMPANY is hereby PROHIBITED from writing any new business in the individual health insurance market in the state of Idaho for a period of five (5) years from the initial date of BRIDGESPAN HEALTH COMPANY'S notice to the Director on May 12, 2017.

IT IS SO ORDERED.

DATED this 8th day of January, 2018.

STATE OF IDAHO
DEPARTMENT OF INSURANCE

DEAN L. CAMERON
Director

NOTIFICATION OF RIGHTS

This Order constitutes a final order of the Director. Any party may file a motion for reconsideration of this final order within fourteen (14) days of the service date of this order. The Director will dispose of the petition for reconsideration within twenty-one (21) days of its receipt, or the petition will be considered denied by operation of law. *See*, Idaho Code § 67-5246(4).

Pursuant to Idaho Code §§ 67-5270 and 67-5272, any party aggrieved by this final order may appeal it by filing a petition for judicial review in the district court of the county in which: (1) the hearing was held; or (2) the final agency action was taken; or (3) the aggrieved party resides or operates its principal place of business in Idaho; or (4) the real property or personal property that was the subject of the agency decision is located. An appeal must be filed within twenty-eight (28) days of: (a) the service date of this final order; or (b) an order denying a petition for reconsideration; or (c) the failure within twenty-one (21) days to grant or deny a petition for reconsideration, whichever is later. *See*, Idaho Code § 67-5273. The filing of a petition for judicial review does not itself stay the effectiveness or enforcement of the order under appeal.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 8th day of January, 2018, I caused a true and correct copy of the foregoing DECISION AND ORDER to be served upon the following by the designated means:

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