No. 101683-2

SUPREME COURT
OF THE STATE OF WASHINGTON

THE EVERETT CLINIC, PLLC,

Respondent,

v.

PREMERA and PREMERAFIRST, INC.,

Petitioners.

MEMORANDUM OF *AMICUS CURIAE* UNITED POLICYHOLDERS

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A. INTRODUCTION

Washington has long been in the vanguard in the United States in advancing the cause of universal access to health care through health insurance, for which cost containment for health care services is essential. Our Legislature has clearly and specifically expressed its concerns about the anti-competitive consolidation of health care services that result in monopolistic price-setting by health care providers.

Division I's opinion is oblivious to the immediate 50% rate hike patients of Eastside Family Medicine Clinic ("EFMC") experienced as a result of the Everett Clinic's ("TEC") takeover. That rate hike will, in turn, affect health insurance plans and employers, many of whom will reduce subsidies for employee health care or even reduce wages to compensate for increased costs.

United Policyholders ("UP") believes that this Court should grant review of Division I's opinion. Division I condones the already too rampant consolidation in the health care

marketplace, the attendant cost escalation for patients, and the resultant increase in health insurance premiums that concentration causes. Ultimately, TEC will use its market power derived from provider concentration in the health care market for anticompetitive purposes.

This is a "Supreme Court case." At its root, this Court should construe agreements between health care providers and insurers to foster competition and eschews monopolistic pricing of services in a health care market increasingly dominated by health care conglomerates. That is an interpretation consistent with Washington's public policy. Division I's opinion failed to do that, meriting this Court's review. RAP 13.4(b)(4).

B. INTEREST OF *AMICUS CURIAE*

As noted in its motion for leave, UP is a § 501(c)(3) tax-exempt organization that provides information to, and serves as a voice for, insurance consumers in all 50 states. UP offers a health insurance policyholder perspective on the parties' issues here.

C. STATEMENT OF THE CASE

UP acknowledges the statements of the case in the parties' pleadings. Lost in the Division I opinion are certain key points:

- TEC is owned ultimately by the large health care conglomerate, United Health Group;
- TEC wants a "road to essentiality" in the Washington health care services marketplace, a design to further consolidate the provision of health care services;
- TEC acquired EFMC, a Bellevue primary care group that had an existing service contract with Premera;
- The Premera/EFMC agreement barred assignment by EFMC of its obligations to others, and the Premera/EFMC contractual obligations, including rates, remained in place even if there was a change in EFMC's ownership or control;
- The Premera/TEC agreement had similar provisions;
- EFMC imposed an immediate rate increase in excess of 50% on its patients once TEC's control became effective;
- Snohomish County consumers were adversely impacted by TEC's conduct. https://www.heraldnet.com/news/everett-clinics-spat-with-premera-lifts-the-curtain-on-price-increases/.

D. ARGUMENT WHY REVIEW SHOULD BE GRANTED

(1) Health Care Reform and Health Care Cost Containment Policy in Washington

As a backdrop to the issues in this case, it is important to note that Washington has long been in the vanguard of expanding health insurance availability toward the goal of universal health care access for its citizens.

In 1987, our Legislature enacted the Basic Health Plan ("BHP"), RCW 70.47, a program designed to extend health insurance to Washingtonians not covered by Medicaid, Medicare, or private health insurance. RCW 70.47.020(9)(a)(v). By the early 1990's, 24,000 previously uninsured persons who did not qualify for Medicaid were enrolled in the BHP. Peter Jacobsen, *Washington State Health Services Act: Implementing Comprehensive Health Care Reform*, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4193508/.

The 1990 Legislature created the Washington Health Care Commission to develop a comprehensive reform strategy to address increasing health care costs, increasing health insurance

premiums, and the increasing numbers of uninsured in Washington. *Id*. Its report in 1992 was the impetus for enactment of Washington's landmark Health Services Act of 1993 ("HSA"), a comprehensive health care act that anticipated the federal Patient Protection and Affordable Care Act of 2010 (ACA).[1] Laws of 1993, ch. 492. The HSA imposed individual and employer health insurance mandates, expanded the BHP and Medicaid enrollments, and aggressively contained costs to ensure provider and health insurer price competition. *Id*. Despite significant revisions to HSA in 1995, Laws of 1995, ch. 265, the Legislature found that "the basic health plan has been an effective program in providing health coverage for uninsured residents," and intended that enrollment be "expanded expeditiously." *Id*. § 1(1)-(2).

Again anticipating the ACA, in 2007 the Legislature charged the Office of Financial Management with the

[1] 124 Stat. 119.

coordination of public and private efforts to promote health service availability and health care cost-effectiveness, and to gather health care data, RCW 43.370.020, and thereby develop a statewide health resources strategy evaluating availability, quality, and cost of services. RCW 43.370.030.

The 2021 Legislature created the Universal Health Care Commission, RCW 41.05.840, to implement the recommendations of the Health Care Cost Transparency Board created in 2020 to examine provider and insurer fees and charges. *See* RCW 70.390.020.

Recognizing that *competition* as to services was essential to limiting health care costs, as did the HSA, the Legislature mandated that patients have a right under RCW 70.01.030 to information from providers regarding fees and charges to allow them to make price-based consumer choices.

Washington has long been committed to provider cost containment in its regulation of the health care industry and health insurers. The Office of the Insurance Commissioner

regulates numerous types of health insurance including group health insurance agreements, RCW 48.21; health insurance pools, RCW 48.41; managed care plans, RCW 48.43; health insurers, RCW 48.44; HMOs, RCW 48.46; health care service contractors, RCW 48.44.020; entities that contract with providers for prepayment of health care services, RCW 48.44.010(9); Medicare supplemental insurance, RCW 48.66; health savings accounts, RCW 48.68; and long term care insurance, RCW 48.84, 48.85.

The State regulates health services directly because the health care marketplace too often fails to restrain costs. *National Gerimedical Hosp. & Gerontology Center v. Blue Cross of Kansas City*, 452 U.S. 378, 101 S. Ct. 2415, 691 L. Ed. 2d 89 (1981). Since at least 1974, Congress has endeavored to control health care costs by state and local health care planning and regulation of excessive facilities. *Id*. at 386 (Congress was concerned that "marketplace forces in the industry failed to produce efficient investment in facilities and to minimize the

costs of health care."). Implementing the federal directives, the Legislature directed the Department of Health to administer a certificate of need program, RCW 70.38.015, whose purpose is to control provider costs by preventing over capacity of health care facilities, often by competing providers, that drive up the cost of health care services. *St. Joseph Hosp. v. Dep't of Health*, 125 Wn.2d 733, 735, 887 P.2d 891 (1995); *Overlake Hosp. Ass'n v. Dep't of Health*, 170 Wn.2d 43, 50, 239 P.3d 1095 (2010). In *St. Joseph Hosp.*, this Court unambiguously noted that the central purpose of certificate of need was to control health care costs because the marketplace did not. 125 Wn.2d at 735-36.

Not to be overlooked, the State itself is a purchaser of health care and health insurance for public employees and persons in numerous public programs. It has a direct interest in cost containment. The Legislature directed the state's Health Care Authority to develop and implement a health care cost containment program for the state's own purchases of health care and insurance. RCW 41.05.021; RCW 43.41.160.

Washington's policy goal is universal health care access for its citizens through the provision of health insurance, but that goal cannot be implemented, absent effective cost control strategies, including health care provider competition, so that costs that are reimbursed or paid for by health insurance are kept as low as the market permits.

(2) Washington's Public Policy Disfavors Concentration of Health Provider Services and Favors Provider Competition

Washington public policy is committed to price competition in the health care market and in health insurance, but it has also manifested an interest in preventing concentration in that market because such concentration adversely impacts the price competition policy noted herein.

The American health care market has experienced a dramatic increase in provider concentration.[2] The last two

[2] UnitedHealth Group, TEC's parent company, acquired Change Healthcare, a health care data firm, for $13 billion. https://www.forbes.com/sites/brucejapsen/2022/10/03/unitedhealth-closes-optums-13-billion-change-healthcare-

decades have witnessed "significant consolidation in healthcare," including a "notable increase" after passage of the ACA. Jacob Snow, Ronnie Solomon, Kyle Quackenbush, *The Efficiencies Defenestration: Are Regulators Throwing Valid Healthcare Efficiencies Out the Window?*, 27 Competition: J. Anti., UCL & Privacy Sec. Cal. L. Assoc. 73, 77 (2018). Generally, consolidation results in *higher prices*. *Id*. at 79. In the hospital sector that involves a third of U.S. health spending and 6% of gross domestic product, a majority of the U.S. geographical areas were dominated by only one to three hospital systems, and 80% of the American hospital market was "highly concentrated," within the meaning of joint Department of

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deal/?sh=2bcaa7007ccc. It also announced yet another recent merger, buying the LHC Group that provides home health care services for $5.4 billion, combining that organization into United Health's Optum Health division. https://abcnews.go.com/Business/wireStory/unitedhealth-buy-lhc-group-54-billion-83737503. Optum itself was equally busy in buying providers in 2022-23. https://www.beckersasc.com/asc-news/a-year-of-optums-biggest-deals-a-timeline.html.

Justice/Federal Trade Commission guidelines. The attendant result of such concentration was that mergers or acquisition, like that of EFMC by TEC, result in higher prices, and actually result in lower clinical quality. Zack Cooper, Martin Gaynor, *Addressing Hospital Concentration and Rising Consolidation in the United States*, https://onepercentsteps.com/policy-briefs/addressing-hospital-concentration-and-rising-consolidation-in-the-united-states/.

The same concentration in hospital services has occurred as to medical providers, particularly during the COVID epidemic. In 2016, for example, 65% of the metropolitan statistical areas were "highly concentrated" for specialists, and 39% for primary care providers. *See* Brent Fulton, *Health Care Market Concentration Trends in the United States: Evidence and Policy Responses*, https://www.healthaffairs.org/doi/10.1377/hlthaff.2017.0556; Karyn Schwartz, Eric Lopez, Matthew Rae, Tricia Neuman, *What We Know About Provider Concentration*,

https://www.kff.org/health-costs/issue-brief/what-we-know-about-provider-consolidation/. These analyses confirm that health care provider concentration leads to higher health care prices.

Washington has long recognized the application of antitrust principles to health care providers. *Hubbard v. Medical Service Corp. of Spokane County*, 59 Wn.2d 449, 367 P.2d 1003 (1962). In recent years, the Legislature has emphasized special vigilance for competitiveness among providers. The 2019 legislation placed special emphasis on competitiveness in the health care marketplace. *See* Appendix.

The Legislature directed parties to any material change by providers including merger, acquisition, or affiliation to give notice of same to the Attorney General. RCW 19.390.030. The Final Bill Report for SHB 1607, https://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bill%20Reports/House/1607-S%20HBR%20FBR%2019.pdf?q=20220406170614, indicated

that this notice was intended to allow the Attorney General to fully utilize his/her antitrust powers under the Consumer Protection Act, RCW 19.86 ("CPA").[3] The Legislature may further refine that public policy.

Washington's public policy is to restrain increases in health care costs by restricting provider concentration and encouraging provider competition. This policy is manifest, given Washington's commitment to universal health care access by broadening health insurance availability in conjunction with rigorous health care cost containment.

(3) The Premera/EFMC Agreement Must Be Construed in Accordance with Washington Public Policy

Division I's overall analysis of TEC's agreement with EFMC is oblivious to the public policy referenced above. That

[3] The Attorney General has utilized such powers to restrain efforts at concentration by the Franciscan Health conglomerate. *See State v. Franciscan Health System*, 388 F. Supp. 3d 1296 (W.D. Wash. 2019); 2019 WL 3756709 (consent decree).

public policy must be assessed in the interpretation of the Premera/EFMC and Premera/TEC agreements by the courts. Contractual provisions that violate public policy are unenforceable. *E.g.*, *LK Operating LLC v. Collection Group LLC*, 181 Wn.2d 48, 331 P.3d 1147 (2014) (RPCs); *Mendoza v. Rivera-Chavez*, 140 Wn.2d 659, 999 P.2d 29 (2000) (insurance policy). Division I should have construed the agreements in a fashion consistent with Washington public policy that disfavors health care provider concentration because of its ultimate impact on patient costs and health care premiums, and against the authorization for the significant rate increases that TEC and EFMC advocate. It did not do so. Instead, Division I's opinion condones further health care market consolidation.

Division I neglects to even mention the 50% cost jump to EFMC patients from TEC's takeover. Indeed, far from involving pay for "higher quality," as TEC asserts in its answer at 22, EFMC's patients did not receive higher quality services. They merely sustained a dramatic price increase for which they had no

warning for the *same* services they had received at the *same* location from the *same* staff and equipment.

Division I's decision subjectively interprets the evidence in a fashion contrary to Washington consumer protection law and public policy. Its finding that separate geographic markets cannot establish separate products in a tying arrangement is illogical, not in the interest of consumers, nor supported by the case law. Separate geographic markets make separate product markets, especially in a service industry.

The second basis for Division I's conclusion, that there was no coercion because TEC forced higher rates, rather than purchase of an additional product, is also contrary to law and consumers' interests. Premera's choice to defend this lawsuit and retain EFMC in its network in the interests of consumers should not defeat the CPA or tying claims that the case law supports. Division I lost sight of Washington public policy that is *against* the health care provider market concentration it condones. Review is merited. RAP 13.4(b)(4).

E. CONCLUSION

Washington has been a leader in health care reform over the years, advancing the cause of universal health care through general access to affordable health insurance. In turn, only where there is healthy competition in the health care marketplace and attendant costs are kept low can that policy be advanced.

But Division I's opinion fosters concentration among healthcare providers ensuring large increases in costs and rendering health insurance premiums unaffordable, thereby jeopardizing the State's goal of universal health care.

Division I condoned a reading of the EFMC/Premera agreement that resulted in EFMC's 50% jump in rates due to TEC's anti-competitive market position is unjustifiable.

UP believes the Court should grant review pursuant to RAP 13.4(b) and affirm the trial court's decision.

This document contains 2,312 words, excluding the parts of the document exempted from the word count by RAP 18.17.

DATED this 3rd day of April, 2023.

Respectfully submitted,

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APPENDIX

RCW 19.390.010:

It is the intent of the legislature to ensure that competition beneficial to consumers in health care markets across Washington remains vigorous and robust. The legislature supports that intent through this chapter, which provides the attorney general with notice of all material health care transactions in this state so that the attorney general has the information necessary to determine whether an investigation under the consumer protection act is warranted for potential anticompetitive conduct and consumer harm. This chapter is intended to supplement the federal Hart-Scott-Rodino antitrust improvements act, Title 15 U.S.C. Sec. 18a, by requiring notice of transactions not reportable under Hart-Scott-Rodino reporting thresholds and by providing the attorney general with a copy of any filings made pursuant to the Hart-Scott-Rodino act.

DECLARATION OF SERVICE

On said day below I electronically served a true and accurate copy of the ***Memorandum of Amicus Curiae United Policyholders*** in Supreme Court Cause No. 101683-2 to the following:

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I declare under penalty of perjury under the laws of the State of Washington and the United States that the foregoing is true and correct.

DATED: April 3, 2023 at Seattle, Washington.

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