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Writer's Direct Dial

April 7, 2016

VIA EMAIL - Donna.Jerry@state.vt.us

Ms. Donna Jerry
Senior Health Policy Analyst
Green Mountain Care Board
89 Main Street, Third Floor, City Center
Montpelier, Vermont 05620

Re: United Healthcare of New England, Inc.: Request for Jurisdictional regarding Determination Certificate of Need process

Dear Ms. Jerry:

On behalf of our client, United Healthcare of New England, Inc. ("UHC NE"), we are writing to correct our letter of March 14, 2016 requesting a jurisdictional letter from the Green Mountain Care Board ("GMCB") regarding a proposed expansion of service area. The March 14 letter incorrectly stated the current counties served by UHC-NE and the counties covered by the proposed expansion. This letter restates the request and corrects that error.

UHC NE previously submitted a request for a jurisdictional letter to the GMCB regarding the Certificate of Need ("CON") process on March 3, 2014, which is attached to this letter as Exhibit 1. As stated in that letter, UHC NE applied for a Certificate of Authority from the Vermont Department of Financial Regulation to operate in the state as a foreign health maintenance organization to offer Medicare Advantage plans and/or Medicare Part D

Prescription Drug plans ("MAPD" plans) - with enrollment beginning January 1, 2015. UHC NE is a subsidiary of UnitedHealth Group, based in Minnesota. UHC NE developed the MAPD plans and began offering those plans on January 1, 2015 in Vermont. UHCNE is currently authorized to provide services in five Vermont counties - Chittenden, Washington, Windham, Bennington and Rutland. UHC NE is now proposing to expand its service area in Vermont to five additional counties - Addison, Chittenden, Lamoille, Orange and Windsor.

In the March 3, 2014 letter we addressed why UHC NE's business in Vermont would not constitute a "new healthcare project" under paragraphs (1) through (6) of 18 V.S.A. § 9432(8)(B) and thus would not be subject to the CON review process. In a response letter dated March 24, 2014, GMCB stated that "the project as represented is not subject to Certificate of Need Review." The response letter is attached as Exhibit 2 to this letter.

The expansion of UHC NE's MAPD plan business in Vermont does not change the factors addressed in our March 3, 2014 letter, which remain true in regard to the expanded business. Accordingly, we submit that the section 9432(8)(B) factors remain inapplicable.

UHC NE requests a jurisdictional letter regarding the planned expansion of its MAPD plan business. We appreciate the GMCB's review of these matters. Because of UHC NE's contracting process with the Centers for Medicare and Medicaid Services, we initially requested a response by April 1, 2016. Should you have any questions or need additional information, please let us know. Thank you very much.

Sincerely,

MITCHELL, WILLIAMS, SELIG,
GATES & WOODYARD, P.L.L.C.

By Margaret A. Johnston
Margaret A. Johnston

MAJ:kj

EXHIBIT 1

MITCHELL | WILLIAMS

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March 3, 2014

VIA ELECTRONIC MAIL (Michael.Donofrio@state.vt.us)

Mr. Michael Donofrio
General Counsel
Green Mountain Care Board
89 Main Street, Third Floor, City Center
Montpelier, Vermont 05620

Re: UnitedHealthcare of New England, Inc.: Request for Jurisdictional Determination regarding Certificate of Need process

Dear Mr. Donofrio:

Our firm is assisting UnitedHealthcare of New England, Inc. ("UHC NE") in its application for a Certificate of Authority from the Vermont Department of Financial Regulation ("DFR") to operate in the state as a foreign health maintenance organization ("HMO") and related matters. UHC NE is domiciled in Rhode Island; it seeks the HMO license in Vermont so it can offer Medicare Advantage plans and/or Medicare Part D Prescription Drug Plans ("MAPD" plans)—with enrollment beginning January 1, 2015. UHC NE is a subsidiary of UnitedHealth Group, based in Minnesota.

UHC NE understands that a prerequisite for such a license is to demonstrate to the DFR that it has received from the Green Mountain Care Board ("GMCB") either a Certificate of Need ("CON") or a written determination by the GMCB that it does not have jurisdiction over the matter. Accordingly, this letter notifies the GMBC of UHC NE's intent to provide MAPD services in Vermont and to request a jurisdictional letter regarding the applicability of the CON process, as described in Vermont statutes and regulations.[1] For reasons explained below, UHC NE believes the MAPD business it proposes is not a "new healthcare project" for which a CON is required under 18 V.S.A. § 9434(a).

To offer MAPD services beginning January 1, 2015, UHC NE must complete the Centers for Medicare and Medicaid Services ("CMS") contracting requirements, which include demonstration of DFR licensure by approximately May 1, 2014.[2] Accordingly, we request a jurisdictional determination from GMCB as soon as possible.

---

[1] 18 V.S.A. § 9431, et seq.; Vt. Admin. Code § 4-7-4:4.100, et seq.

[2] Under federal law, insurers and HMOs must obtain a license in the state in which they seek to contract with CMS, and states have ongoing oversight over solvency. All areas relating to ongoing operations other than solvency, such as provider network adequacy, quality of care, member or provider grievances and appeals and rate setting, are governed solely by CMS under federal preemption. *See* 42 C.F.R. § 422.402, .404 (Medicare Advantage), 422 C.F.R. § 423.440 (Medicare Prescription Drug Plans). *While this letter does not reach the issue of preemption we*

Analysis of Jurisdictional Issues

1. **Summary Description of Project: UHC NE's proposed business in Vermont.** As stated above, UHC NE intends to offer MAPD plans to Medicare beneficiaries in three Vermont counties—Chittenden, Washington and Windham. UHC NE does not provide health care services directly—it is not a "staff model" HMO that hires doctors and other health care providers as employees or owns hospitals or other facilities. UHC NE instead contracts—either directly, or indirectly through affiliates or other subcontractors—with an independent network of physicians, hospitals and other licensed health care practitioners, and reimburses these providers to provide direct care to its enrollees (in an amount or proportion described in an enrollee's CMS-approved Evidence of Coverage). The MAPD benefits to be offered by UHC NE in Vermont must be approved by CMS as a prerequisite to contracting with CMS. In general, such plans will offer benefits available through original Medicare, plus additional benefits and an annual out-of-pocket maximum to help beneficiaries budget for health care costs. The plans may include Part D prescription drug coverage, or such coverage may be offered through separate, stand-alone plans.

2. **Applicability of the CON process to UHC NE's proposed business in Vermont.** An HMO is a non-hospital "health care facility" as defined in 18 V.S.A. § 9432(8)(B). Accordingly, GMCB would have jurisdiction under section 9434(a) over any "new healthcare projects" that fall within paragraphs (1)-(6) of that subsection. As analyzed further below, UHC NE submits that its proposed business *does not* constitute a "new healthcare project" under any of these six paragraphs.

1) The construction, development, purchase, renovation, or other establishment of a health care facility, or any capital expenditure by or on behalf of a health care facility, for which the capital cost exceeds $1,500,000.00.

Conclusion: Not applicable.

Analysis: UHC NE's proposed business in Vermont does not fit within this definition because it does not involve capital costs exceeding $1,500,000. From our discussions, I understand that a memorandum from more than a decade ago by the head of the agency then responsible for the CON process stated that establishment of an HMO in the state would fall under this paragraph. This memorandum, however, preceded a 2003 amendment to section 9434(a)(1) that added the modifying phrase regarding a capital cost threshold (see below, with new language underlined and deleted language struck through):

> "~~the~~ The construction, development, purchase, renovation, or other establishment of a ~~new~~ health care facility ~~except for the purchase or lease of an existing health~~

---

provide, for the GMCB's information, a copy of the Preemption Memorandum we submitted to the DFR with the application for a Certificate of Authority.

~~care facility other than the purchase of a hospital~~, or any capital expenditure by or on behalf of a health care facility, for which the capital cost exceeds $1,500,000.00."

Public Act 53, Sec. 10 (2003).

The language of paragraph 1, as amended above, remains the same in the current statute. In unambiguous terms, the language reflects that the "establishment of a health care facility" is further modified by "for which capital costs exceed $1,500,000." Because of the placement of commas before and after the phrase "or any capital expenditure by or on behalf of a health care facility," such phrase is parenthetical in nature and the language after the parenthetical— "for which capital costs exceeds $1,500,000"—applies to both the phrase "The construction, development, purchase, renovation, or other establishment of a health care facility" and "or any capital expenditure on behalf of a health care facility."

We interpret "capital costs" to be very similar to "capital expenditure," which is defined in section 9432 as:

> "an expenditure for the plant or equipment which is not properly chargeable as an expense of operation and maintenance and includes acquisition by purchase, donation, leasehold expenditure, or lease which is treated as capital expense in accordance to the accounting standards established for lease expenditures by the Financial Accounting Standards Board, calculated over the length of the lease for plant or equipment, and includes assets having an expected life of at least three years. A capital expenditure includes the cost of studies, surveys, designs, plans, working drawings, specifications and other activities essential to the acquisition, improvement, expansion, or replacement of the plant and equipment."

UHC NE will not incur capital costs exceeding $1.5 million in providing MAPD services in Vermont. Capital costs, if any, will be very minimal. MAPD operations (claims, enrollment, customer service, etc.) for UHC NE and other UnitedHealth Group-affiliated MAPD plans are centralized in Minnesota to support all such plans across the country. While UnitedHealth Group maintains some functions in its New England regional offices (such as management and oversight of the product, sales and network management), it owns no real estate in Vermont. While UHC NE may need some additional staff to support the product in Vermont (for clinical, sales and/or supervising agents, for instance), these additional staff persons are likely to work remotely, rather than in owned or leased office space.

Accordingly, the MAPD services do not meet the definition of a "new healthcare project under paragraph (1).

2) **A change from one licensing period to the next in the number of licensed beds of a health care facility through addition or conversion, or through relocation from one physical facility or site to another.**

Conclusion: Not applicable.
Analysis: UHC NE does not have licensed beds, as it does not provide direct inpatient health care services. It contracts directly or indirectly with independent hospitals and other facilities which have such licensed beds, but these facilities are regulated separately by the GMCB.

3) **The offering of any home health service, or the transfer or conveyance of more than a 50 percent ownership interest in a health care facility other than a hospital.**

Conclusion: Not applicable.
Analysis: UHC NE is not a home health agency, nor does its licensure in Vermont to provide HMO services involve a change in ownership.

4) **The purchase, lease, or other comparable arrangement of a single piece of diagnostic and therapeutic equipment for which the cost, or in the case of a donation the value, is in excess of $1,000,000.00. For purposes of this subdivision, the purchase or lease of one or more articles of diagnostic or therapeutic equipment which are necessarily interdependent in the performance of their ordinary functions or which would constitute any health care facility included under subdivision 9432(8)(B) of this title, as determined by the board, shall be considered together in calculating the amount of an expenditure. The board's determination of functional interdependence of items of equipment under this subdivision shall have the effect of a final decision and is subject to appeal under section 9381 of this title.**

Conclusion: Not applicable.
Analysis: UHC NE's licensure in Vermont to provide HMO services does not involve the purchase of medical equipment. As noted above, UHC does not directly provide health care services to Medicare beneficiaries.

5) **The offering of a health care service or technology having an annual operating expense which exceeds $500,000.00 for either of the next two budgeted fiscal years, if the service or technology was not offered or employed, either on a fixed or a mobile basis, by the health care facility within the previous three fiscal years.**

Conclusion: Not applicable.
Analysis: The phrase "health care service" is not defined in the statutes or regulations applicable to the GMCB's CON process, but the phrase appears to be equivalent to "health services," which is defined in 18 V.S.A. § 9431 as "activities

and functions of a health care facility that are directly related to care, treatment or diagnosis of patients." As described above in the summary of UHC NE's proposed services in Vermont, the HMO is not a staff model HMO that directly provides health services through employed physicians or owned hospitals and other facilities. It contracts with independent providers and reimburses them for providing care to Medicare beneficiaries who have enrolled with the HMO. While UHC NE will monitor and manage care, and will seek to promote high quality of care by its network of providers (as required under its contract with CMS), the HMO is not a direct provider of such care. Indeed, its entry into the state will not add to or diminish the number of providers of direct health services in Vermont. Accordingly, the MAPD services do not meet the definition of a "new healthcare project' under paragraph (5).

6) **The construction, development, purchase, lease, or other establishment of an ambulatory surgical center.**

Conclusion: Not applicable.
Analysis: UHC NE will not directly, own, lease or otherwise establish such a facility.

We appreciate the GMCB's review of these matters. Should you have questions or need additional information, please let us know. Thank you.

Sincerely,

MITCHELL, WILLIAMS, SELIG,
GATES & WOODYARD, P.L.L.C.

By 
Charles B. Cliett, Jr.

CBC:cd
Enclosure

(Submitted as Part of DFR Application)

Exhibit A

Application for Certificate of Authority to do Business as a Foreign HMO

Memorandum on Federal Preemption and Medicare Advantage/Part D ("MA-PD") Plans ("Preemption Memorandum")

This memorandum accompanies the Application for a Certificate of Authority to do business as a foreign HMO ("Application") filed with the Vermont Department of Financial Regulation, Insurance Division by UnitedHealthcare of New England, Inc., a Rhode Island company ("UHC New England"). As explained in the Application, UHC New England intends to provide benefit plans in Vermont solely through the Medicare Advantage and Medicare Part D prescription drug programs (collectively "MA Plans"). All of UHC New England's MA Plans will be offered to Medicare beneficiaries pursuant to contracts with the Centers for Medicare and Medicaid Services ("CMS"). Accordingly, as described below, federal law preempts certain state oversight of UHC New England, and also prohibits taxation of premiums or application of other state assessments directed at insurance business. This memorandum is cross-referenced in the Application as the "Preemption Memorandum."

1. **Preemption of laws or regulation governing operations of MA-PD Plans.**

Federal statutes provide that standards established by the Medicare Modernization Act and implemented by CMS "supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency) with respect to MA [P]lans . . ." 42 U.S.C. §1395w-26(b)(3). These preemption standards also are included in substantially similar language in the regulations implementing the Medicare Modernization Act at 42 C.F.R. §422.402.[1] In the order adopting these regulations, CMS stated that:

> "State licensing laws under Federal preemption are limited to State requirements for becoming State licensed, and cannot be extended to other requirements that the State might impose on licensed health plans that absent Federal preemption must be met as a condition for keeping a State license . . . . For example, State-licensing requirements may include requirements such as filing articles of incorporation with the appropriate State agency, or satisfying State governance requirements. However, under Federal preemption, State licensing laws may not be extended to include rules that apply to State licensed health plans which we believe would include network adequacy requirements for MA [P]lans."

See 70 Fed. Reg. 4588, 4664.

CMS has expanded on its explanation of preemption parameters in Chapter 10 of the Medicare Managed Care Manual. In section 30.2 of Chapter 10, CMS states:

> "In general, a valid State licensure requirement is one that determines whether an entity at the time of application is capable of offering health insurance in the State. We differentiate between requirements that govern the fitness of the organization to serve as a health insurer or risk bearing entity, and the requirements that govern the ongoing operation of how, where or to whom the entity provides benefits, where it provides benefits, or to whom it provides benefits."

[1] This regulation from Chapter 422 relates to the Medicare Advantage Program (Part C), a substantially identical regulation regarding preemption governs Part D prescription drug components of to be offered in UHC New England's MA Plans. *See* 42 C.F.R. §423.440(a).

While CMS defers to states on issuing Certificates of Authority and ongoing solvency oversight, CMS takes an active role in regulating areas preempted under federal law. Subparts in Part 422 of the federal regulations describe how CMS regulates beneficiary protections (Subpart B, including network access and provider contracting standards in 42 C.F.R. § 422.112); quality (Subpart D); additional requirements regarding relationships with providers (Subpart E); grievances and appeals relating to medical necessity determinations and other matters that impact Medicare beneficiaries (Subpart M); and marketing requirements (Subpart V). One of the purposes of preemption is to avoid duplication and possible inconsistent regulation in these areas. Specific examples are provided in a table in Chapter 10, Section 60 of the Medicare Managed Care Manual, which can be viewed at the following link:

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c10.pdf

2. Preemption of taxes or other assessments directed at insurers.

Federal law states that "[n]o State may impose a premium tax or similar tax with respect to payments to" MA Plans. 42 U.S.C. § 1395w-24(g). CMS regulations provide that "[n]o premium tax, fee, or other similar assessment may be imposed" by any state or political subdivision of a state "with respect to any payment CMS makes on behalf of MA [Plan] enrollees under subpart G of this part, or with respect to any payment made to MA [P]lans by beneficiaries, or payment to MA [P]lans by a third party on a beneficiary's behalf." 42 C.F.R. §422.404 (a).[2]

While CMS does not prohibit taxes applying to businesses generally (42 C.F.R. § 422.404(b)), these provisions do prohibit application of premium taxes or assessments such as those by guaranty funds or state risk pools aimed at the insurance industry.

[2] This regulation from Chapter 422 relates to the Medicare Advantage Program (Part C); a substantially identical regulation regarding preemption governs Part D prescription drug components of UHC New England's MA Plans. *See* 42 C.F.R. §423.440(b).

VERMONT

EXHIBIT 2

Green Mountain Care Board
89 Main Street
Montpelier, VT 05620

[phone] 802-828-2177
www.gmcboard.vermont.gov

SENT ELECTRONICALLY

March 24, 2014

Mr. Charles B. Cliett, Jr., Esq.
Mitchell, Williams, Selig, Gates & Woodyard, P.L.L.C.
425 West Capitol Avenue, Suite 1800
Littlerock, Arkansas 72201

RE: Docket No. GMCB-005-14con, Develop a Health Maintenance Organization in Vermont to Offer Medicare Advantage Plans and/or Medicare Part D Prescription Drug Plans

Dear Mr. Cliett:

Thank you for your letter dated March 3, 2014 regarding the proposal of UnitedHealthcare of New England, Inc. to develop a health maintenance organization in Vermont to offer Medicare Advantage Plans and/or Medicare Part D Prescription Drug Plans with enrollment beginning January 1, 2015. UnitedHealthcare of New England is a subsidiary of UnitedHealth Group, based in Minnesota.

Based on your letter dated March 3, 2014, the project as represented is not subject to Certificate of Need review. However, if there are changes in the type or scope of your proposal as you proceed with implementation, you must notify the Green Mountain Care Board immediately so that we may determine whether CON review is required.

If you have further questions, please do not hesitate to contact me at 802-828-2918.

Sincerely,

S/ Donna Jerry
Health Policy Analyst

cc. Kaj Samson, Vermont Department of Insurance