The Honorable Robert S. Lasnik

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON AT SEATTLE

ANDREA SCHMITT; ELIZABETH MOHUNDRO; and O.L. by and through her parents, J.L. and K.L., each on their own behalf, and on behalf of similarly situated individuals, Plaintiffs, v. KAISER FOUNDATION HEALTH PLAN OF WASHINGTON; KAISER FOUNDATION HEALTH PLAN OF WASHINGTON OPTIONS, INC.; KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST; and KAISER FOUNDATION HEALTH PLAN, INC., Defendants.	CASE NO. 2:17-cv-1611-RSL EXPERT REBUTTAL REPORT OF CHERYL SCOTT, MA

I, Cheryl Scott, declare under the penalty of perjury of the laws of the United States of America, the following:

1. I am the former President and CEO of Group Health Cooperative, now known as Kaiser Permanente Washington ("Group Health"). I began my career at Group Health in 1979. I served as a regional vice president, executive vice president, and then Chief Operating Officer in 1991. I became president and CEO of Group Health in 1997 and served in that role until 2004.

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2. I am a clinical professor at the University of Washington, specializing in health systems and population health and have an endowed professorship: the Cheryl M. Scott – Group Health Cooperative Endowed Professorship, in the Department of Health Systems and Population Health at the University of Washington. At the national level, I have chaired the Alliance of Community Health Plans and the Healthcare Forum and served on the board and executive committee of America's Health Insurance Plans. I was previously a member of the Institute of Medicine's Committee on Redesigning Health Insurance Benefits, Payment and Performance Improvement Programs. I hold a master's degree in health administration from the the University of Washington and am currently Principal of the McClintock Scott Group, a consulting group dedicated to building financially aligned partnerships between providers and health plans. I am currently a board member of a number of entities in the healthcare industry, including Living Goods, Sutter Health, Evolent Health, Progyny, and Evercare.

3. My educational and professional background are detailed in my Curriculum Vitae attached as *Exhibit A.*

4. I have been actively engaged in work regarding health care plans and health care delivery my entire career. I am an expert in health benefit plans, and health financing and delivery and the integration of both on behalf of the patient. I have been requested to review the "Expert Report of Valerie K. Blake," an attorney from West Virginia University, by the attorneys for the Defendants.

5. I have never been retained as an expert in a legal matter before. I have not been deposed or testified as an expert in any case. I am being compensated for my time in this matter at a rate of $250 per hour. My compensation is not contingent upon the nature of my opinions or the outcome of litigation.

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MATERIALS CONSIDERED

6. I have reviewed the expert report of Valarie K. Blake, JD (herein "Blake"), and select articles cited by Blake. I am not a lawyer and do not offer any opinion with respect to any legal opinions contained in Ms. Blake's report.

MY RESPONSE

7. Ms. Blake's usage of key terms is not consistent with how they are generally understood in the industry, which makes her opinions confusing. To ensure precision and clarity, those terms are defined below.

a. Government Health Insurance

Government health insurance means health insurance programs sponsored by the federal or state government. The two main types of government health insurance are Medicare and Medicaid. Everything that is not government health insurance is "commercial health insurance."

b. Commercial Health Insurance

Commercial health insurance is generally understood to include all health insurance plans offered on the commercial market. This includes all (small to large) employer group plans, , healthcare union trusts, and individual health plans. This is a very broad general category and *includes* plans offered by non-profit Blue Cross and Blue Shield, non-profit managed care plans, and for-profit indemnity health insurance.

(i) Non-Profit Managed Care Plans

Non-profit managed care plans contract with health care providers and medical facilities to provide comprehensive benefits to enrollees at a

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fraction of the patient out of pocket costs of indemnity health insurance. Any excess revenue back goes back to either internal operating capital (e.g., information systems) or directly to the provision of healthcare services. They do not have shareholders and are instead charitable organizations (under §501(c)(3)) answerable and accountable to their patients, providers, and communities in which they operate. Health Maintenance Organizations (HMOs) are a common example. Managed care HMO organizations primarily control expenses by making the delivery of health care more efficient and evidence-based at the provider level.

(ii) Blue Cross and Blue Shield Plans

The Blake report specifically refers to non-profit Blue Cross and Blue Shield plans and, therefore, this definition is intended to clarify the characteristics of a Blue Cross and Blue Shield plan in the state of Washington. Blue Cross and Blue Shield plans are commercial health plans that also typically offer comprehensive benefits. They primarily use negotiated rates with a network of providers (Preferred Provider Organizations) and enrollee copay and/or coinsurance to control costs.

(iii) Indemnity Health Insurance

Indemnity health insurance is a specific type of commercial health insurance offered by traditional insurance companies. In practice, indemnity health insurance had a much more limited set of benefits (many times allowing the employer to choose those benefits), paid a set fee for a

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> specific medical service and contractually allowed providers to balance bill directly to the enrollee to recoup their total charges. Historically, indemnity health insurance was heavily concentrated in the individual and small group market. Using such methods as limited benefits, set fee schedules, lifetime maximum coverage and balance billing allowed these plans to have a premium price point much lower than comprehensive plans. From what I can discern from Ms. Blake's report, what she is actually describing in paragraphs 9-13 of her report is for-profit indemnity health insurance.

8. Non-profit managed care HMO plans and Blue Cross Blue Shield plans both fall into the general category of "commercial health insurance," since they are not government health insurance, but they are an entirely different model than indemnity health insurance. Blake confuses the definition of "commercial health insurance" by using for-profit indemnity insurance practices to describe all "commercial insurers" and contrasting those practices with non-profit Blue Cross and Blue Shield plans. Blake at ¶ 9; 12. This highlights that Blake is really comparing for-profit indemnity health insurance with non-profit managed care. Even though both these plan types fall under the broad umbrella of commercial health insurance, actual practices and offerings were entirely different.

9. In addition, the "brief history" recounted by Blake (¶¶9-13) is the history of for-profit indemnity health insurance. It is most definitely <u>not</u> the history of not-for-profit managed care organizations such as Group Health Cooperative.

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10. Blake's misuse of the term "commercial insurers" not only creates confusion, but undermines the entire basis for her opinions concerning the "commercial insurance market's" exclusion of people with disabilities as it relates to this case.

11. Group Health was established by physicians and consumer activists, with significant support from the granges, unions, and consumers. Group Health was founded on the principles of providing outstanding medical care, "serving the greatest number of people under consumer cooperative principles without discrimination," providing comprehensive health care services and reducing cost as a barrier to health care. These principles were adopted in its bylaws. See Walt Crowley, *Group Health Cooperative (GHC), Part I: Planting the Seeds 1911-1945*, available at https://www.historylink.org/File/7531, sections of which were cited in the Blake Report.

12. Group Health was a 501(c)(3) non-profit organization. It was not a for-profit enterprise and it had no shareholders. Group Health operated on the principles of a healthcare cooperative. What this means in practice is that members could amend the bylaws and they elected the Board of Trustees. Members often voiced their opinions before the Board of Trustees, including advocating for specific benefits to be covered. Group Health was established as one of the first consumer-directed healthcare organization in the country. See, Walt Crowley, *Group Health Cooperative (GHC), Part II: Open for Business, 1946-1950*, available at https://www.historylink.org/File/7546. As a non-profit HMO, Group Health was founded on fundamentally different principles than the indemnity insurers described by Ms. Blake. These principles permeated how Group Health thought about benefits, health care, and pricing.

13. True to its co-op roots, Group Health continued to take input from both members and providers throughout my tenure. Members could, at any time, petition for any benefits

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packages they would like to add to Group Health's individual/family benefits plan at Group Health's annual meeting and did so. Interestingly, in my 25 years at Group Health, I am unaware of a single member advocating for coverage of hearing aids under Group Health's base benefits plan or otherwise petitioning for hearing aid coverage at the annual meeting. Additionally, Members had voting rights as to the board of trustees, and served as board members. This co-op business model was nothing like the indemnity insurance (which she mislabels as "commercial insurance") described by Blake. Group Health certainly did not follow the "traditional pathway of commercial insurance" as Blake uses that term.

14. None of the examples used by Blake in her "brief history" apply to Group Health.

15. One of the major facets of indemnity insurance (Blake's so-called "commercial insurance") described by Blake to support her conclusion is the use of blanket exclusions on preexisting conditions prior to the Affordable Care Act ("ACA"), which she contends was an effort to limit coverage for the disabled. Blake at ¶ 12.

16. The founders of Group Health always believed that a blanket exclusion for pre-existing conditions should not be used. Group Health Cooperative did not have a blanket exclusion of pre-existing conditions on employer plans throughout my tenure.

17. Another point emphasized by Blake to further her conclusions is that indemnity insurance used "experience rating" as a central business model to weed out disabled people from the ranks of their insured membership, to select only healthy, able-bodied people. Blake at ¶ 12. "Experience rating" was a practice used by some indemnity insurers in the individual and small group health insurance market, in which the proposed insured's claims experience and medical history was used in determining whether coverage would be offered and at what rate.

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18. Blake contrasts this with the "community rating" used by the non-profit managed care model, employed, for example, by Blue Cross and Blue Shield. Blake at ¶ 12. "Community rating" does not look at an individual's claim experience or medical history, but instead rates based on geographic area. Blake correctly observes that the "experience-rating" model led to "cream-skimming," which priced high risk individuals out of the indemnity insurance market, leaving them to be covered by the non-profit managed care organizations such as Blue Cross and Blue Shield. Blake at ¶ 12.

19. The problem with Blake's argument is that Group Health had always used "community rating" in the individual and group market just like Blake describes for Blue Cross and Blue Shield. Group Health did not "experience rate" and did not consider an individual's medical history, and did not rate up, exclude or limit benefits on that basis. As a non-profit like Blue Cross and Blue Shield, Group Health was not concerned about replicating the "competitive business model" of the typical for-profit indemnity insurer, to the extent one existed. Group Health was the one serving those "high risk individuals" that Blake observes were shut out of the traditional indemnity insurance market by experience rating.

20. Blake next opines that the passage of Medicaid and Medicare entrenched the role of indemnity insurance as a product for "healthy and able-bodied" because there was less of a market or incentive to design plans to meet the needs of those with disabilities. Blake at ¶ 18. Once again, this has nothing to do with Group Health. Group Health early on accepted Medicare patients and began offering Medicare participants full Group Health coverage in 1966. It also joined in developing health care programs for low income people. See, Walt Crowley, *Group Health Cooperative (GHC), Part IV: From Medicare to HMO, 1966-1980,* available at

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https://www.historylink.org/File/8255. These efforts continued throughout my tenure and Medicare Advantage plans were a substantial part of Group Health's business.

21. Even more to the point, all of Group Health's plans provided "comprehensive benefits" for the treatment of chronic and acute conditions, without distinction. Comprehensive benefits (also called "major medical") provide broad coverage of a wide range of healthcare services such inpatient, outpatient, and emergency care, with caps on a member's out of pocket expenses. In addition to the managed health care delivery model, Group Health also strongly emphasized preventative care, but when our members suffered from disabling or other conditions, we took care of them. Group Health was always a health care provider first and foremost.

22. This is in stark contrast to how the indemnity insurers managed costs: offering only skinny benefits, and applying blanket preexisting condition exclusions and other traditional insurance mechanisms, but perpetuating the fee-for-service model with no control on the cost of the care itself.

23. The final point Blake uses to support her conclusion is based on misguided speculation that Group Health has been directed by employers to design discriminatory benefits plans. Prior to the ACA, small group plans that could not afford the comprehensive health benefits offered by Group Health and the Blue Cross Blue Shield plans, could negotiate the scope of benefits with the for-profit indemnity insurance plans. Group Health, as a managed care organization, offered only the comprehensive benefit plan. Employers could not pick and choose benefits to exclude from the base plan.

24. Relatedly, in my long experience in the industry, the most common demand from employers was that they wanted the most comprehensive benefits possible at affordable premiums. I have never heard any employer group at Group Health seeking to cut benefits in order to

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discriminate against the disabled. As a non-profit HMO, Group Health was an innovator in efficient health care delivery at the most affordable cost for the greatest number of people. Premiums were controlled by negotiating the underlying costs of health care services, not negotiating the scope of benefits. This reduction in cost is baked-in to the nature of an HMO, as the cost of in-network care is the primary force driving premiums. Cuts to benefits for the disabled to reduce premiums were never proposed or considered, much less acted upon. Any such proposal would have been immediately reversed by the Board. Ms. Blake's speculation about the role of employers in discriminatory benefit design has nothing to do with the reality of how Group Health operated.

25. Blake's ultimate opinion—that Group Health's origins were like most indemnity insurers and therefore, Group Health shared their discriminatory motivations—is simply wrong. Her opinion appears to be based on a fundamental misunderstanding of non-profit managed care organizations, and Group Health in particular. She also relies on law review articles, which do not apply in describing how healthcare coverage was offered during my tenure in the state of Washington. Her opinion further ignores the irrefutable fact that Group Health did not engage in any of the practices of the indemnity insurers which Blake attempts to impute to Group Health; and instead was aligned with the not-for-profit managed care model exemplified by Blue Cross Blue Shield, hailed by Blake. Hearing aids, along with optical hardware (eye glasses) and dental services, have traditionally been considered ancillary to comprehensive benefit plans, and this standard has been codified in Medicare and by the Office of the Insurance Commissioner. Blake's opinion that Group Health's benefit plans, and the exclusion of hearing aids in some plans in particular, was motivated by discrimination against disabled people, is totally unfounded.

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EXECUTED this 9th day of June, 2023, at Seattle, Washington.

DocuSigned by:
Cheryl Scott
30B6ED8A73B14DA...

Cheryl Scott, MA

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CERTIFICATE OF SERVICE

I, Luci Brock, affirm and state that I am employed by Karr Tuttle Campbell in King County, in the State of Washington. I am over the age of 18 and not a party to this action. My business address is: 701 Fifth Avenue, Suite 3300, Seattle, Washington 98104. On this day, I caused a true and correct copy of the foregoing document to be filed with the Court and served on the parties listed below in the manner indicated.

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☒ Via U.S. Mail
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☒ CM/ECF via court's website

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

Executed on this 20th day of June, 2023, at Seattle, Washington.

s/Luci Brock
Luci Brock
Legal Assistant

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Exhibit A

CHERYL M SCOTT

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cheryl@mcclintockscottgroup.com

EDUCATION

1977 **Master of Health Administration**
Graduate Program in Health Services Administration and Planning
School of Public Health and Community Medicine
University of Washington
Seattle, Washington

1975 **Bachelor of Arts in Communications (Journalism)**
University of Washington
Seattle, Washington

EMPLOYMENT EXPERIENCE

2016 to present **Principal**
McClintock Scott Group

McClintock Scott Group is a consulting group providing broad health care delivery and financing strategy support as well as board advisory services.

2006 to 2016 **Bill and Melinda Gates Foundation**
Seattle, Washington

2007 to present **Senior Advisor in Global Health**

The senior advisor extended the reach and impact of the Foundation's key strategies and initiatives in global health by supporting key healthcare initiatives. Key focus areas included strategy direction for developing global health financing and primary care delivery approaches and strategy counsel to the foundation's Co-Chairs, CEO and the President of Global Health and his Program Directors.

2006 to 2007 **Chief Operating Officer**

Oversight of all major operational functions for the foundation, including Impact Planning and Improvement, Public Policy and External Affairs, Communications, Finance, Information Technology, Human Resources, and Legal. Following Warren Buffett's historic gift in 2006, this role's major contribution was in supporting foundation-wide change initiatives necessary to achieve large and rapid increases in organizational capacity.

1979 to 2005 **Group Health Cooperative**
Seattle, Washington

Group Health is a nonprofit health care system that coordinates care and coverage for 600,000 members. The Group Health family of organizations includes Group Health Cooperative (founded in 1946) and subsidiary Group Health Options, Inc.; Group Health Permanente, a 1000 member physician group that delivers care in Group Health-owned medical centers; a nationally recognized research center (The Center for Health Studies); a charitable foundation (The Group Health Community Foundation); and a network of contracted community providers. Group Health owns inpatient and ambulatory facilities and provides care throughout Washington and Northern Idaho.

1997 to 2004 **President and Chief Executive Officer**

Initial work (1997 – 1999) was to respond aggressively to three significant challenges: the managed care backlash, variable provider relationships and performance, and important but untested affiliations had undermined basic business fundamentals. Key actions included:

Led an organization wide effort to turn around financial performance without compromising mission or patient care with a net effect of reversing losses of over $80 million in 1998 to a $20 million net positive margin in 2000.

Created a public policy initiative to reposition GHC's Medicare Advantage program – renegotiated program with the Centers for Medicare and Medicaid Services based on improving payment equity; worked with chair of House Ways and Means Sub-Committee on Health to integrate long term fix into reform legislation.

From 2000 – 2004, lead a repositioning strategy that resulted in a doubling of net worth in three years (from $200 million to over $400 million), an unprecedented increase in patient satisfaction and significant improvement in staff loyalty. Actions included:

Leadership in repositioning GHC brand and experience: Key attributes included patient focused access improvements (same day access and direct to specialists referrals), an aggressive technology strategy aligned with process redesign (an EMR integrated with the consumer's own personalized Web page that included physician messaging, pharmacy refills, lab reports and patient support information) and an award winning advertising and marketing strategy. Outcomes included a significant increase in the number of patients rating excellent their patient care experience at Group Health (29% to $48%).

Created a market competitive cost structure within GHC's group practice that included a restructured primary care model (16% decrease in direct costs and 20% increase in productivity). Cost initiatives were integrated with a new set of health plan products and services to alleviate historical rate trends.

Conceived, directed and executed a twenty year agreement with large community suburban tertiary hospital to buy land on their campus and to build a $110 million specialty center and to redirect all inpatient operations

out of existing GHC owned hospital to their medical center. Actions resulted in closing our own hospital.

1991 – 1997 **Executive Vice President and Chief Operating Officer**

Main accountabilities were in the effective strategy and performance of the GHC owned and operated delivery system. At that time, operations included 30 primary care facilities, four specialty centers, one tertiary hospital (300 beds) and one community hospital (150 beds), a 150 bed long term care facility and a variety of clinical programs in support of its 350,00 Group Model consumers. Key strategic focus included:

The design and execution of a strategic alliance with a large multispecialty group practice. Components of that strategy included consolidation of the two hospital operations into a single, rationalized inpatient program located at one campus with an intensive set of outpatient and maternity services consolidated at the other; a new joint health plan portfolio; and three jointly owned medical centers. Inpatient per-diem costs were reduced by 50% and with the alliance health plan becoming the plan of choice for major purchasers in the Puget Sound Region with over 100,000 members.

1989 – 1991 **Vice President, Human Resources**

Part of a larger organizational restructure that elevated the position to the Vice President level. Used the restructuring as an opportunity to turn the division into a service oriented function where HR executives' evaluation was anchored by internal customer feedback. Instituted a revamped performance management process (from skills to goals/standards). Created a restructured labor relations unit that emphasized first level interest based problem solving.

1982 – 1989 **Regional Vice President**

Served as operating executive for patient care operations within two separate geographies. Each region was composed of a hospital, specialty center and a network of primary care facilities that served approximately 100,000 consumers. Integrated leadership for physician partnership at every level within the region as well as planned and lead major expansion programs for each regional campus. Focused efforts on program innovations (e.g. census management), team development and operational excellence.

1979 – 1982 **Associate Hospital Administrator**

Provided operational direction for all ancillary and support departments for the 150 bed Eastside Hospital.

1977 – 1979 **Assistant Administrator**
Bernalillo County Medical Center
University of New Mexico
Albuquerque, New Mexico

In this 300-bed teaching county hospital, line responsibility included all ambulatory service and selected professional units. Acted as hospital facility planner and provided staff support to the Board of Directors.

BOARD MEMBERSHIPS

Business and Professional:

Evolent Health, Director (2016 – present); Chair (2022 – present)

Sutter Health, Director (2017 – present); Chair Nom/Gov Committee (2019 -present); Chair CEO Search Committee (2021 – 2022)

Living Goods, Director (2018 – present); Vice Chair, 2021 – present

Progyny, Director (2019 – present)

Evercare (part of the RISE fund), Director (2019 – present)

Recreational Equipment Incorporated (REI), Trustee (2004 – 2016); Chair, Compensation Committee (2009 – 2014); Chair of the Cooperative (2015 -2017)

Providence Health and Services, Trustee (2009 – 2016)

State of Washington Life Sciences Discovery Fund, Trustee (2005 – 2017)

Health Technology Center, Trustee (2000 – 2005); Chair (2004 – 2006)

Alliance for Community Health Plans, Trustee (1997 – 2004); Chair (2002 – 2004)

America's Health Insurance Plans, Trustee (1998 –2004); Co-Chair Planning Committee (2001 –2004)

Healthcare Forum, Trustee (1993 – 1997); Chair (1996 –1997)

COMMUNITY AND PUBLIC POLICY AFFILIATIONS

Public Policy

Institute of Medicine

Committee on Crossing the Quality Chasm Summit: Redesigning Care and Improving Health in Priority Areas (2002 –2003) - Member

Committee on Redesigning Health and Insurance Benefits, Payment and Performance Improvement Programs (2004 – 2005) - Member

University of Washington Health Services Advisory Committee, Chair (2001 – 2007)

Community

John D. Thompson Distinguished Scholar, Yale University School of Public Health, 2011

Cheryl M. Scott/Group Health Cooperative Professorship in Health Care Leadership; School of Public Health; University of Washington – 2005 - present

King County Blue Ribbon Commission on Election Reform, Chair (2005 – 2006)

Alliance for Education, Trustee (1998 – 2005); Chair (2002 – 2003)

United Way of King County, Trustee (1991 – 1996)

PROFESSIONAL AFFILIATIONS

President Emeritus, Group Health Cooperative (2005 – 2006)

Department of Health Services, School of Public Health, University of Washington

Associate Clinical Professor	1999 – 2004
Clinical Professor	2004 – present