IN THE SUPREME COURT
OF THE
STATE OF SOUTH DAKOTA

No. 30207

ORTHOPEDIC INSTITUTE, P.C.; SIOUX FALLS SPECIALTY HOSPITAL, L.L.P.; SIOUX FALLS SPECIALTY HOSPITAL, L.L.P. D/B/A SIOUX FALLS URGENT CARE; SIOUX FALLS SPECIALTY HOSPITAL, L.L.P. D/B/A WORKFORCE OCCUPATIONAL HEALTH AND MEDICAL SERVICES; SIOUX FALLS SPECIALTY HOSPITAL, L.L.P. D/B/A MIDWEST PAIN SPECIALISTS; SIOUX FALLS SPECIALTY HOSPITAL, L.L.P. D/B/A MIDWEST IMAGING; OPHTHALMOLOGY LTD., INC.; and OPHTHALMOLOGY LTD. EYE SURGERY CENTER, L.L.C.,

Plaintiffs and Appellees,

and

SANFORD HEALTH PLAN, INC.,

Defendant and Appellant,

Appeal from the Circuit Court
Second Judicial Circuit
Minnehaha County, South Dakota

The Honorable Rachel R. Rasmussen, Circuit Court Judge

BRIEF OF APPELLANT SANFORD HEALTH PLAN, INC.

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Notice of Appeal of Defendant and Appellant Sanford Health Plan, Inc. filed December 29, 2022

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PRELIMINARY STATEMENT

Appellant-Defendant Sanford Health Plan is referred to as "SHP." Appellee-Plaintiffs are collectively referred to as "Plaintiffs." Individually, Plaintiffs are referred to as follows: "Orthopedic Institute" refers to Plaintiff Orthopedic Institute, P.C.; "Sioux Falls Specialty Hospital" or "SFSH" refers to Plaintiffs Sioux Falls Specialty Hospital, L.L.P. and the "d/b/a" entities listed in the case caption; and "Ophthalmology Ltd." refers to Plaintiffs Ophthalmology Ltd., Inc., and Ophthalmology Ltd. Eye Surgery Center, L.L.C. Citations to "R. [page]" refer to the applicable page number in the Certified Record.

JURISDICTIONAL STATEMENT

Pursuant to SDCL 15-26A-3, Defendant SHP appeals from the circuit court's Memorandum Opinion Granting Plaintiffs' Motion for Summary Judgment and Denying Defendant's Motion for Summary Judgment, dated December 2, 2022, and filed December 5, 2022, and the circuit court's Order Granting Plaintiffs' Motion for Summary Judgment and Denying Defendant's Motion for Summary Judgment, dated December 27, 2022, and filed December 27, 2022, in the above-titled matter. (R. 1257, 1275.)

REQUEST FOR ORAL ARGUMENT

Defendant SHP respectfully requests oral argument.

STATEMENT OF THE ISSUES

1. **Does South Dakota's Any Willing Provider Law, SDCL 58-17J-2, bar health insurers from offering customers the choice of lower cost health insurance options through closed or tiered plans that utilize subsets of a health insurer's panel of providers?**

Contrary to the Any Willing Provider Law's plain text and express purpose, and contrary to this Court's strong presumption against implied repeal, the circuit court concluded that the law does not permit a health insurer to offer lower-cost healthcare options to patients through closed or tiered plans that utilize subsets of a health insurer's panel of providers.

Most apposite authorities:

- SDCL 58-17J-2
- *City of Rapid City v. Estes*, 2011 S.D. 75, 805 N.W.2d 714
- *Faircloth v. Raven Indus., Inc.*, 2000 S.D. 158, 620 N.W.2d 198
- *Steinberg v. S. Dakota Dep't of Mil. & Veterans Affs.*, 2000 S.D. 36, 607 N.W.2d 596

2. **Did the circuit court err in concluding there was no genuine issue of material fact regarding Plaintiffs' willingness to meet the terms and conditions of participating in SHP's plans when it relied solely on a representation by Plaintiffs' counsel that was contradicted by unrebutted evidence, including: (a) evidence that Plaintiffs would not be offered the same contractual terms as those in the contract referenced by Plaintiffs' counsel; and (b) testimony from a plaintiff's corporate representative that there are terms and conditions it would not accept?**

Relying on the representation of Plaintiffs' attorney that was contradicted by unrebutted evidence, including evidence that the purported

terms to which Plaintiffs would agree would not be offered to them, and testimony from Plaintiff Ophthalmology Ltd. that there are terms and conditions it would not accept, the circuit court erroneously concluded that there was no genuine issue of material fact regarding Plaintiffs' willingness to meet the terms and conditions of participating in SHP's plans.

Most apposite authority:

- *Frevert v. Ford Motor Co.*, 614 F.3d 466 (8th Cir. 2010)

STATEMENT OF THE CASE

In 2014, the voters of South Dakota passed Initiated Measure 17 to protect patient choice. That law, the Any Willing Provider Law codified at SDCL Ch. 58-17J ("AWP Law"), prohibits health insurers from obstructing patient choice by excluding a health care provider licensed under the laws of South Dakota from participating on a health insurer's "panel of providers" if the provider meets the conditions in the statute. The AWP Law provides:

> 58-17J-2. Patient choice—Health care provider participation.
>
> > No health insurer…may obstruct patient choice by excluding a health care provider licensed under the laws of this state from participating on the health insurer's panel of providers if the provider is located within the geographic coverage area of the health benefit plan and is willing and fully qualified to meet the terms and conditions of participation as established by the health insurer.

SDCL 58-17J-2.

The text of the AWP Law provides for a single "panel of providers" belonging to the "health insurer." The undisputed record shows that SHP maintains such a panel of providers, which is open to any provider who meets the conditions in the statute. Thus, SHP complies with the law.

Each Plaintiff is already on SHP's panel of providers. The undisputed record also shows that every patient who purchases a Sanford plan has the freedom to choose to be treated by any of Plaintiffs' providers, and to have those services covered by SHP. In short, the undisputed factual record shows that patients currently have freedom to choose any willing provider, as the AWP Law requires.

Plaintiffs are a group of for-profit physician groups and medical facilities located in Sioux Falls. Plaintiffs are not only on SHP's panel of providers, but are also in-network for three of the four major health benefit plans that SHP offers, which encompass approximately 70% of SHP's patient members. Plaintiffs asked the circuit court to construe the AWP Law in a way that would require SHP to make Plaintiffs in-network for every one of its plans, despite unrebutted evidence that doing so would eliminate less expensive healthcare options for many South Dakota residents.

The parties cross-moved for summary judgment, and the Hon. Rachel R. Rasmussen denied SHP's motion and granted Plaintiffs' motion. The

circuit court adopted Plaintiffs' interpretation of the AWP Law, concluding that the law's reference to a "health insurer's panel of providers" does not contemplate a single "panel" belonging to the "health insurer," but instead requires multiple panels, with separate panels for each health insurance plan that every insurer offers.

In so holding, the circuit court effectively re-wrote the AWP Law by replacing the words "health insurer" with "health benefit plans." This interpretation also functionally repeals at least ten provisions of South Dakota's Insurance Code, as well as numerous regulations, by rendering "closed" and tiered plans illegal—contrary to the plain language of the Insurance Code and related regulations.[1] Furthermore, the holding would thwart the express purpose of the AWP Law, which is to protect "patient choice in [the] selection of health care provider[s]." SDCL Ch. 58-17J. The undisputed record shows that requiring SHP to open its focused plans to Plaintiffs and other providers will increase the cost of those plans or cause them to be eliminated entirely.

[1] Closed plans (which SHP calls "focused" plans) rely on narrower networks of providers, which promotes cost-savings that can be passed on to patients. Closed (or focused) plans differ from open plans (which SHP calls "broad" plans), which rely on a wider network of providers but generally are more expensive. Tiered plans allow patients to choose any provider from among a broad network, and pay less or more in cost-sharing based on which tier the in-network provider is in.

Even if the circuit court's interpretation of the statute was correct, it still erred in holding that there was no genuine issue of material fact regarding Plaintiffs' willingness to meet the terms and conditions of participating in SHP's focused plans. The circuit court relied solely on the representation of Plaintiffs' counsel, who testified that Plaintiffs are willing to accept the terms and conditions of a contract that he had reviewed that was between SHP and Sanford Health. The circuit court relied on the lawyer's declaration despite express, unrebutted testimony from one of Plaintiff's corporate representatives that it would *not* accept certain potential SHP terms. Moreover, the record is devoid of evidence that the terms and conditions contained in the contract that Plaintiffs' counsel reviewed—and that Plaintiffs purportedly would accept—would even be offered to Plaintiffs, because Plaintiffs are not similarly situated to other providers currently participating in SHP's focused plans, and the AWP Law does not require identical terms and conditions to be offered to differently situated providers.

The circuit court's memorandum opinion was signed on December 2, 2022, and filed on December 5, 2022. On December 27, 2022, the circuit court issued an order granting Plaintiffs' motion for summary judgment and denying SHP's motion. On December 28, 2022, the circuit court issued a

stay of its order pending this appeal, per stipulation of the parties. SHP filed its notice of appeal on December 29, 2022.

STATEMENT OF THE FACTS

I. The Parties

Defendant *Sanford Health Plan* is a South Dakota taxable nonprofit and is a health maintenance organization governed by SDCL Chapter 58-41. (R. 528 (¶ 2), 373.) SHP is a wholly owned subsidiary of Sanford Health, a South Dakota nonprofit health system headquartered in Sioux Falls, South Dakota. (R. 528 (¶ 2).) SHP ensures that South Dakotans have access to affordable health care—and to providers they want to see—by offering a variety of health benefit plans that give South Dakota patients the ability to choose any South Dakota provider they wish to see at prices that fit their budgets. (R. 514-16 (¶¶ 25, 33); *see* R. 528-31 (¶¶ 3, 12, 21).)

Plaintiffs are a group of for-profit, private medical practices and facilities. (R. 1258.) Plaintiff *Orthopedic Institute, P.C.* ("Orthopedic Institute") is a for-profit medical practice located in Sioux Falls. (R. 509-10 (¶ 3); *see* R. 945.) Some of Orthopedic Institute's physicians have ownership interests in its co-plaintiff, Sioux Falls Specialty Hospital. (R. 1258; *see* R. 510-11 (¶¶ 7-9).)

Plaintiff *Sioux Falls Specialty Hospital, L.L.P.* and the "d/b/a" entities listed in the caption (collectively, "Sioux Falls Specialty Hospital") are for-profit health care entities. (R. 509-10 (¶ 3); *see* R. 887.) Minority ownership interests in Sioux Falls Specialty Hospital are held by physicians associated with co-plaintiffs Orthopedic Institute and Ophthalmology, Ltd. (R. 510-11 (¶¶ 7-9).)

Plaintiffs *Ophthalmology Ltd., Inc., and Ophthalmology Ltd. Eye Surgery Center, L.L.C.* (collectively, "Ophthalmology Ltd.") are for-profit medical practices located in Sioux Falls. (R. 509-10 (¶ 3); *see* R. 1092.) Some of Ophthalmology Ltd.'s physicians also have ownership interests in Sioux Falls Specialty Hospital. (R. 510-11 (¶¶ 7-9).)

II. South Dakota's Any Willing Provider Law

In 2014 South Dakotans voted to adopt the AWP Law. The express purpose of the law is to protect patient choice of health care providers, as the title and text of the law make clear:

> 58-17J-2. Patient choice—Health care provider participation.
>
> No health insurer…may obstruct patient choice by excluding a health care provider licensed under the laws of this state from participating on the health insurer's panel of providers if the provider is located within the geographic coverage area of the health benefit plan and is willing and fully qualified to meet the terms and conditions of participation as established by the health insurer.

SDCL 58-17J-2. It is undisputed that "the sole focus and intent of the [AWP] statute is patient choice." (R. 1270.)

III. SHP's Panel of Providers

In compliance with the AWP Law, SHP maintains a panel of providers that is open to any willing provider that fulfills the conditions of the statute. (R. 513 (¶ 20); *see* R. 530.) To ensure quality of care and service, SHP establishes certain requirements ("terms and conditions") that a health care provider must meet in order to provide covered care to patients enrolled in any SHP benefit plan. (R. 513 (¶¶ 20-21); *see* R. 530.) Specifically, providers must be credentialed with SHP to ensure they meet SHP's quality standards. In addition, health care providers must have a contractual provider agreement, which is individually tailored to providers. (R. 531 (¶ 14).) As a result, the terms and conditions are not uniform across providers. (*See id.*; R. 1215 (¶ 16).) Providers that agree to meet these terms and conditions, that are licensed in South Dakota, and that are located in the geographic coverage area of one or more SHP health benefit plans, comprise SHP's panel of providers—including every Plaintiff in this lawsuit (R. 513 (¶¶ 20-22); *see* R. 530.)

IV. SHP's Health Benefit Plans

SHP offers a variety of health benefit plans. (R. 511 (¶ 13); *see* R. 531.) Each plan is structured differently, with the goal of giving patients and their families choices in health insurance based on their varying financial circumstances, health care needs, and care preferences. (R. 514 (¶ 25); *see* R. 528-31 (¶¶ 3, 12, 21).) SHP offers four primary plans: Simplicity, Signature Series, Sanford PLUS, and Sanford TRUE. (R. 514 (¶ 26); *see* R. 531.) The plans cover care provided through "networks" of health care providers. A provider wishing to be "in-network" for any SHP health benefit plan must first be on SHP's panel of providers. (R. 513-14 (¶¶ 20-24); *see* R. 530-31).) From there, different plans have networks of different sizes. (R. 512-16 (¶¶ 14-16, 18, 27-29, 33); *see* R. 189-90, 215, 528, 531, 652, 654.) Some networks include SHPs entire panel of providers, while other networks consist of smaller sub-sets of the full panel. (R. 516-17 (¶¶ 33, 40), *see* R. 191, 531.) A provider that is on SHP's panel of providers may be "in-network" for a particular benefit plan, depending on structure of the plan and the specifically negotiated contractual agreements between providers and SHP. (R. 514 (¶ 24); *see* R. 531.)

For example, patients (and employers providing benefits) can select a less-expensive "focused" plan that has a narrower network of providers. (R.

512-17 (¶¶ 15-16, 28, 30-31, 33, 36-37, 39-40), *see* R. 528-31.) Or they can choose a "broad" plan that covers care provided by a larger network of providers—including each of the Plaintiffs—in exchange for higher premiums and cost share. (R. 513-17 (¶¶ 18, 27, 30, 32, 39-40); *see* R. 529-32.) SHP requires that every patient be provided with the choice of a broad plan that will allow them to choose to see any provider within the full panel, and to have that care covered by insurance. (R. 516-17 (¶ 39); *see* R. 531, 191, 691.) In addition, South Dakota employers that elect to offer a SHP focused plan to their employees must also offer a broad plan. (R. 516-17 (¶¶ 39-40); *see* R. 531, 191, 691.) SHP also offers "tiered" plans that include the entire broad provider network, and give patients the option within that broad network to choose providers in a less-expensive tier. (R. 517 (¶ 41); *see* R. 532, 654.)

Sanford TRUE Plan – Focused Network

Sanford TRUE is a "closed plan" as provided by the South Dakota Insurance Code. (*See* R. 531 (¶ 16).) *See also* SDCL 58-17F-1(1) (defining "closed plan"). Sanford sometimes refers to TRUE and similar plans as "focused plans," which are generally more affordable than broad plans, in part because they have fewer in-network providers than broad plans. (R. 512-15 (¶¶ 15-16, 28, 30-31); *see* R. 190, 193, 529, 654). Focused/closed

plans are also less expensive thanks to efficiencies in patient care coordination, claims processing, and medical record retrieval, among other things. (R. 512-13 (¶¶ 16-17); *see* R. 528-29, 193.) Further, by directing in-network care to a smaller number of physicians, SHP can also negotiate lower reimbursement rates. (R. 512-13 (¶¶ 16-17); *see* R. 528-29, 193, 1198-99.) SHP then passes these savings on to patients as lower insurance premiums. (R. 512-13 (¶¶ 16-17); *see* R. 529.)

Creating a focused plan is complex. (R. 512-13 (¶ 17); *see* R. 528.) SHP uses many different factors to determine which health care providers should be in-network, to decide which procedures should be covered and at what rates, and to ensure the plan provides adequate, affordable and quality coverage. (*Id*.) Such factors include quality of care programs and practices, geographic location, the range of services provided, outcomes of procedures, the ability to service the particular network's need, cost efficiency, historical utilization, willingness to comply with medical management utilization review, anticipated level of medical staff's interest, strength of staff, price, accreditation status, case mix, patient mix (including the number of uninsured and low income patients served), degree of utilization, compatibility of information technology, and size. (*Id*.) The TRUE network is comprised primarily of providers that have a contract with Sanford Health

and other non-Sanford Health providers who are necessary to meet network adequacy requirements. (R. 514-15 (¶ 28); *see* R. 190, 654.)

Simplicity Plan and the Signature Series Plan – Broad Network

SHP's Simplicity Plan and Signature Series Plan are broad plans, which have the greatest number of in-network providers. (R. 514 (¶ 27); *see* R. 531, 189, 654.) Because these plans provide coverage for a broad scope of providers and because they provide comprehensive out-of-network coverage, the cost to provide these broad plans is much higher. (R. 513 (¶ 18); *see* R. 529.) Unlike focused plans, broad plans lack the efficiencies mentioned above. (*See id.*; R. 1212.) SHP also has less leverage to negotiate favorable reimbursement rates with providers since the opportunity to provide care is spread across a large number of providers. (R. 513 (¶ 18); *see* R. 529.) This results in less savings to pass onto patients. (*Id.*) Each of the Plaintiffs in this lawsuit are in-network for the Simplicity and Signature Series plans. (R. 514 (¶ 27); *see* R. 530.)

Sanford PLUS Plan – Broad Network with Tiers

Sanford PLUS is a "tiered plan" offered to large employers. (R. 515 (¶ 29); *see* R. 531, 654.) PLUS divides SHP's broad network—comprised of SHP's entire panel of providers, including Plaintiffs—into two tiers. (R. 654, 531 (¶ 17).) Patients' costs are based on the tier of the provider from whom

they choose to receive care. (R. 654, 531 (¶ 17), 216, 218.) Tier 1 has the lowest cost-share to patients, and includes Sanford's large care system of Sanford Health providers and facilities (akin to a focused plan). (R. 654, 216, 218.)) Tier 2 has a higher patient cost-share, and expands beyond the Sanford Health System (akin to a broad plan). (R. 654, 216, 218, 531 (¶¶ 17, 20).) Patients with PLUS can choose to treat with any provider in Tier 1 (which does not include Plaintiffs) or in Tier 2 (which does include every Plaintiff) and receive in-network benefits. (R. 532 (¶ 23), 216.)

V. The AWP Law & the Circuit Court's Decision

On cross motions for summary judgment, the parties asked the circuit court to interpret the meaning of "health insurer's panel of providers" in the AWP Law:

> No health insurer, including the South Dakota Medicaid program, may obstruct patient choice by excluding a health care provider licensed under the laws of this state from participating on the *health insurer's panel of providers* if the provider is located within the geographic coverage area of the health benefit plan and is willing and fully qualified to meet the terms and conditions of participation as established by the health insurer.

SDCL 58-17J-2 (emphasis added).

The circuit court agreed with Plaintiffs that "panel of provider" is "plan-specific and not insurer-specific." (R. 1271.) This holding effectively

rewrote the statute to replace the words "health insurer" with "health benefit plan." The circuit court's declaration provided:

> [The court] DECLARES the Any Willing Provider Law enacted through Initiated Measure 17 by the voters of South Dakota does not allow a health insurer to exclude a health care provider from a *health benefit plan's panel of providers* who is (1) licensed under the laws of South Dakota; (2) located within the geographic coverage area of the health benefit plan; and (3) willing and fully qualified to meet the terms and conditions of participation as established by the health insurer.

(R. 1273-74, 1276 (emphasis added).)

After adopting a "plan-specific" interpretation of the AWP Law, the circuit court also held that there were no genuine issues of material fact regarding Plaintiffs' willingness to accept the terms and conditions for participating on each of SHP's plans. (R. 1267-68.) The circuit court's holding relies on a representation by Plaintiffs' attorney that Plaintiffs were willing to meet the terms and conditions of a previously-executed contract between SHP and Sanford Health. (*Id.*; R. 1158; *see generally* R. 233-92.) But the circuit court failed to address evidence in the record that the terms of this other contract would not be offered to the Plaintiffs, and there is no evidence in the record—other than their lawyers' testimony—that such terms would be available to the Plaintiffs. (*See* R. 531 (¶ 14), 1215 (¶¶ 14-16).) The circuit court also failed to address unrebutted evidence—testimony from a Plaintiff's corporate representative—that contradicts the

attorney's affidavit. Specifically, Plaintiff Ophthalmology Ltd.'s representative testified that there are terms and conditions it would not be willing to accept. (R. 522 (¶¶ 63-64); *see* R. 1064-65.)

SHP appeals from the circuit court's orders granting summary judgment to Plaintiffs and denying summary judgment to SHP. (R. 1290.)

ARGUMENT

The purpose of South Dakota's Any Willing Provider, SDCL Ch. 58-17J, is clear: it aims to ensure "patient choice in the selection of healthcare providers." (R. 1273.) The plain text of the statute is also clear: a health insurer may not exclude any willing provider who fulfills the statutory criteria from participating on the "*health insurer's* panel of providers." SDCL 58-17J-2 (emphasis added). The statute thus contemplates a single panel of providers that belongs to the health insurer, not multiple panels corresponding to every health benefit plan.

The circuit court erred in several material ways:

- It impermissibly re-wrote the statute by erasing the words "health insurer" and substituting the words "health benefit plan"—thus rendering the AWP Law's term "health insurer" meaningless.
- The holding results in the implied repeal of at least ten statutes in South Dakota's Insurance Code, SDCL Title 58 that allow health insurers to offer closed and tiered plans, as well as numerous regulations.

- It relied on an affidavit from Plaintiffs' attorney to conclude that no genuine issue of material fact exists regarding Plaintiffs' willingness to accept certain terms and conditions. In doing so, the circuit court ignored evidence that (a) such terms and conditions would not be available to Plaintiffs; and (b) a Plaintiff's corporate representative testified that some terms and conditions would *not* be acceptable.

These errors require reversal and entry of judgment for SHP.

Standard of Review

Both issues on appeal are subject to *de novo* review. The interpretation of the AWP Law presents a question of law that the Court reviews *de novo*. *Bertelson v. Allstate Inc. Co.*, 2009 S.D. 21, ¶ 11, 764 N.W.2d 495, 498. The circuit court's conclusion that there was no genuine issue of material fact regarding Plaintiffs' willingness to accept SHP's terms and conditions is also a question of law reviewed *de novo*. *Smith Angus Ranch, Inc. v. Hurst*, 2021 S.D. 40, ¶ 13, 962 N.W.2d 626, 629 ("[The Court] give[s] no deference to the circuit court's decision . . . [and] determine[s] only whether a genuine issue of material fact exists and whether the law was correctly applied." (citation omitted)).

The standard for summary judgment is well-established, *Work v. Allgier*, 2018 S.D. 56, ¶ 8, 915 N.W.2d 859, 861, and this Court applies the "same test as the trial court," *Fisher v. Kahler*, 2002 S.D. 30, ¶ 5, 641 N.W.2d 122, 125. To obtain summary judgment, the moving party must

show that there are no genuine issues of material fact and that it is entitled to judgment as a matter of law. *Work*, 2018 S.D. 56 at ¶ 8, 915 N.W.2d at 861. The Court reviews the evidence in the light most favorable to the nonmoving party and all reasonable doubts are resolved against the moving party. *Id.*

VI. The Circuit Court's Interpretation Re-Writes the Plain Text of the AWP Law, Requires the Implied Repeal of Numerous Statutes and Regulations, and Thwarts the AWP Law's Express Purpose.

The plain language of the AWP Law requires only a single panel of providers, which belongs to the health insurer. Contrary to Plaintiffs' argument, the statutory language does not mandate a separate panel for every plan, or every tier within a plan. The undisputed record shows that SHP permits any willing provider to join its panel of providers, including Plaintiffs. Therefore, SHP complies with the law. The circuit court, however, adopted Plaintiffs' "plan-specific" interpretation, which contradicts the plain text of the law, fails to follow this Court's mandatory presumption against implied repeal, and thwarts the express purpose of the law. Accordingly, the Court should reverse the decision of the circuit court and direct the circuit court to enter judgment in favor of SHP.

VII. The Plain Language of the Statute Requires a Single "Panel of Providers" That Belongs to the Health Insurer.

"The purpose of statutory construction is to discover the true intention of the law, which is to be ascertained primarily from the language expressed in the statute." *City of Rapid City v. Estes*, 2011 S.D. 75, ¶ 12, 805 N.W.2d

714, 718 (citation omitted). "The intent of a statute is determined from what the Legislature said, rather than what the courts think it should have said, and the court must confine itself to the language used." *Id.* (citation omitted); *Peters v. Great W. Bank, Inc.*, 2015 S.D. 4, 859 N.W.2d 618; *Long v. State*, 2017 S.D. 78, ¶ 13, 904 N.W.2d 358, 364. Courts apply traditional rules of statutory interpretation when interpreting voter initiatives or referenda. *See, e.g.*, *State ex rel. Palmer v. Hart*, 655 P.2d 965 (Mont. 1982) ("The same rules applicable to judicial interpretation of legislation enacted by the legislature apply to the interpretation of initiatives."); *Bird-Johnson Corp. v. Dana Corp.*, 833 P.2d 375, 376 n.3 (Wash. 1992) ("[I]t has long been the rule that initiatives are to be interpreted according to the general rules of statutory construction." (cleaned up)).

The plain language of the AWP Law requires a single panel of providers that belongs to the "health insurer." In concluding that the statute instead requires multiple panels corresponding to every plan that SHP offers, the circuit court impermissibly re-wrote the statute to say something very different than what the voters of South Dakota passed.

The AWP Law prohibits SHP from obstructing patient choice by "excluding a health care provider…from participating on the health insurer's panel of providers…." SDCL 58-17J-2. The text of the statute provides that

the "panel of providers" belongs specifically *to the health insurer*—here, SHP. The AWP Law *does not say* the "health benefit plan's" panel of providers. Under the statute, "health insurer" and "health benefit plan" are specifically defined terms, *see* SDCL 58-17J-1(1)-(2), and the statute clearly provides that the "panel of providers" belongs to the "health insurer." Consequently, there need not be multiple panels of providers corresponding to every plan a health insurer may offer.

If the AWP Law's term "panel of providers" was meant to be plan-specific rather than insurer-specific, the statute would have been drafted with precise language to say so. In fact, the AWP Law's drafters had a handy model in South Dakota's 1990 "Any Willing Pharmacy" law. *See* SDCL 58-18-37(1). The pharmacy statute expressly prohibits health insurers from denying any licensed pharmacy the right to participate "as a participating provider *for any policy or plan* on the same terms and conditions as are offered to any other provider of pharmacy services *under the policy or plan*." *Id.* (emphasis added). *See also* SDCL 58-18-38 (requiring health benefit programs to allow "any pharmacy licensed" to "elect to participate *in the plan* under the terms and conditions then offered . . . ." (emphasis added)).

With the "Pharmacy" law as a long-established example, the drafters of the AWP Law knew how to make a "panel of providers" plan-specific if they had intended to do so. They did not. Instead, the AWP Law uses markedly different language, expressly providing that the panel of providers belongs to the "health insurer." That choice of language must be given effect. *See Steinberg v. S. Dakota Dep't of Mil. & Veterans Affs.*, 2000 S.D. 36, ¶ 10, 607 N.W.2d 596, 600 ("Surely if the legislature had wanted to insert the word 'injury' after 'major contributing cause,' it would have done so."); *Stanton v. Hills Materials Co.*, 1996 S.D. 109, ¶¶ 1, 11, 553 N.W.2d 793, 795 (reversing circuit court's award of lump-sum attorney fees under workers' compensation statute and explaining that "[h]ad the legislature intended a different result, it could have said so"); *Bird-Johnson Corp.*, 833 P.2d at 377 (omission of fifteen words from legislation on which the voter initiative was patterned was a "clear indication" that the law was designed to function differently).[2]

Instead of reading the AWP Law's language according to its plain terms, the circuit court declared that the AWP Law should be read as if its

[2] The circuit court's opinion also conflates the concept of a "panel of providers" with being "in-network" for a particular plan. But the AWP Law does not refer to a provider being "in-network." Were the law intended to require health insurer's to permit any willing provider to be in-network for any health benefit plan, it easily could have said so.

drafters had used "plan-specific" language that they could have used, but decided not to use. (R. 1271.) The circuit court then rewrote the law to reflect what it concluded the drafters should have written:

> [The court] DECLARES the Any Willing Provider Law enacted through Initiated Measure 17 by the voters of South Dakota does not allow a health insurer to exclude a health care provider from a *health benefit plan's* panel of providers who is (1) licensed under the laws of South Dakota; (2) located within the geographic coverage area of the health benefit plan; and (3) willing and fully qualified to meet the terms and conditions for participation as established by the health insurer.

(R. 1273-74, 1276 (emphasis added).)[3]

The circuit court's declaration runs contrary to this Court's long-standing principles of statutory construction, which requires interpreting the language that a statute's drafters actually used. As this Court has repeatedly said, "[T]he intent of a statute is determined from what the Legislature said, rather than what the courts think it should have said, and the court must confine itself to the language used." *City of Rapid City*, 2011 S.D. 75, ¶ 12, 805 N.W.2d at 718 (citation omitted) (reversing summary judgment based on erroneous interpretation of city ordinances); *Long*, 2017 S.D. 78, ¶ 13, 904 N.W.2d at 364; *Peters*, 2015 S.D. 4, ¶ 7, 859 N.W.2d at 621.

[3] The circuit court's declaration interprets the statute as plan-specific, not tier-specific, and therefore does not bar the use of tiered networks as in SHP's PLUS plan.

The circuit court's declaration is also problematic because it renders the statutory term "health insurer" meaningless by essentially deleting it from the phrase "health insurer's panel of providers" and replacing it with "health benefit plan." But courts must avoid interpretations that nullify statutory language. *See Faircloth v. Raven Indus., Inc.*, 2000 S.D. 158, ¶ 6, 620 N.W.2d 198, 202 ("We assume that the Legislature intended that no part of its statutory scheme be rendered mere surplusage."). This alone is grounds for reversal. *See, e.g., Nielson v. AT&T Corp.*, 1999 S.D. 99, ¶¶ 8, 15-16, 597 N.W.2d 434, 438-39 (reversing grant of summary judgment based on interpretation that rendered part of the statute meaningless); *Hollman v. S.D. Dept. of Social Servs.*, 2015 S.D. 21, ¶ 9, 862 N.W.2d 856, 859 (same).

* * *

The AWP Law's text is clear: it clearly applies to a "health insurer's panel of providers." The circuit court's declaration changes the statutory text to language that was available to the law's drafters, but that they chose not to use. In doing so, the circuit court's declaration changes the statute's meaning. This was reversible error.

VIII. The Circuit Court's Holding Would Implicitly Repeal Provisions of the South Dakota Insurance Code that Allow Closed and Tiered Plans.

The maxim "context is king" is especially true in statutory interpretation. As this Court has often instructed, the legislative intent is to

be determined in light of "related enactments" on the same subject. *Stanton*, 1996 S.D. 109, ¶ 11, 553 N.W.2d at 795; *see City of Rapid City*, 2011 S.D. 75, ¶ 12, 805 N.W.2d at 718 ("Statutes are construed to be in pari materia when they relate to the same person or thing, to the same class of person or things, or have the same purpose or object."). Likewise, "[w]here conflicting statutes appear, it is the responsibility of the court to give a reasonable construction to both, and to give effect, if possible, to *all provisions under consideration*, construing them together to make them harmonious and workable." *Karlen v. Janklow*, 339 N.W.2d 322, 323 (S.D. 1983) (emphasis added). As a corollary, this Court strongly disfavors implied repeal of South Dakota statutes, and has admonished lower courts to "refrain from negating a legislative act unless it is demanded by manifest necessity." *Faircloth v. Raven Indus., Inc.*, 2000 S.D. 158, ¶ 10, 620 N.W.2d 198, 202; *Karlen*, 339 N.W.2d at 323 ("Repeal by implication will be indulged only where there is a manifest and total repugnancy.").

The concepts of "closed" and "tiered" plans are woven into the structure of South Dakota's Insurance Code, of which the AWP Law is a part. *See* SDCL Title 58. SHP's interpretation maintains harmony between the AWP Law and the Insurance Code because a health insurer can continue to offer closed and tiered plans if it complies with the requirement of the

AWP Law to maintain a panel of providers open to providers who meet the conditions of the statute. But Plaintiffs' "plan-specific" interpretation—adopted by the circuit court—implicitly repeals at least ten statutory provisions and nullifies numerous regulations, contrary to this Court's clear mandate. *Faircloth*, 2000 S.D. 158, ¶ 10, 620 N.W.2d at 202; *Karlen*, 339 N.W.2d at 323.

As used throughout the Insurance Code, a "closed plan" is "a managed care plan or health carrier that requires covered persons to use participating providers under the terms of the managed care plan or health carrier and does not provide any benefits for out-of-network services except for emergency services." SDCL 58-17F-1(1); *see* SDCL 58-17G-1(1) (same); 58-18A-53(3) (defining "closed panel plan"); 58-18A-64 ("Under the terms of a closed panel plan, no benefits are payable if the covered person does not use the services of a closed panel provider."). In other words, the Insurance Code expressly allows insurers to limit participation of providers in certain benefit plans.

Typically, closed plans are designed to provide more affordable health care options to patients. (*See* R. 529 (¶ 6), 644, 1198.) Health insurers achieve this by contracting with a selective network of providers, which can

reduce costs in patient care and administration and foster competition among providers leading to lower rates. (R. 529, 644, 1198, 1212-14.)

Closed plans are integral to the operation of health maintenance organizations like SHP. (R. 644; *see* R. 529-30, 1212-14.) South Dakota's Insurance Code devotes an entire chapter to HMOs. *See* SDCL Ch. 58-41. That chapter expressly permits HMOs to operate closed plans that are limited to certain providers only. *See* SDCL 58-41-2 ("Nothing in this chapter prohibits a health maintenance organization . . . from issuing contracts to enrollees on a *preferred provider*, *exclusive provider*, or *closed panel* basis." (emphasis added)). Numerous other provisions throughout the Insurance Code also expressly contemplate closed plans:

- SDCL 58-17F-1 – defines "closed plan" for purpose of network adequacy standards chapter;
- SDCL 58-17F-11(3) – clarifies chapter does not require health carriers to contract with specific providers or more providers than necessary to maintain an adequate network;
- SDCL 58-17F-11(7) – entitles health carriers to terminate provider contracts without cause upon sixty days written notice;
- SDCL 58-17G-1 – defines "closed plan" for purpose of quality assessment and improvements chapter;
- SDCL 58-17G-4 – requires quality improvement activities of health carriers offering closed plans;
- SDCL 58-17I-1 – defines "closed plan" for purpose of grievance procedure chapter;

- SDCL 58-18A-53 – defines "closed panel plan" for purpose of chapter governing coordination of benefits;
- SDCL 58-18A-58 – defines "plan" to include closed plans for purpose of chapter;
- SDCL 58-18A-64 – provides that no benefits are payable under a closed plan if a person does not use an in-network provider;
- SDCL 58-18A-66 – directs order of benefit payments including when closed plans are involved.

The South Dakota Insurance Code and supporting regulations similarly recognize the importance of tiered plans—a type of preferred provider plan. *See, e.g.*, SDCL 58-41-2; ARSD 20:06:58:20. (*See also* R. 644.) Tiered plans typically have a single network of providers but incentivize seeking care from a list of preferred providers within that network to have claims paid at the highest level. (*See id.*; R. 216.) Patients with tiered plans can seek care from a non-preferred (but still in-network) provider, but the care may be paid at a lower level. (*See* R. 644, 216.) Like closed plans, tiered plans can reduce patient costs by creating efficiencies in patient care and administration, fostering competition between providers, and more. (R. 529-32 (¶¶ 6, 17, 25).) Tiered plans also give patients the freedom to choose their providers. (R. 532 (¶ 23).) Notably, the same provision authorizing HMOs to offer closed plans also permits them to offer plans on a preferred provider basis. *See* SDCL 58-41-2 ("Nothing in this chapter prohibits a health maintenance organization . . . from issuing

contracts to enrollees on a *preferred provider*, exclusive provider, or closed panel basis." (emphasis added)). Many South Dakota insurance regulations also recognize a health insurer's right to offer plans on a preferred provider/tiered basis:

- ARSD 20:06:13:02(14) – Medicare advantage plans include preferred provider organization plans;
- ARSD 20:06:56:10 – permits use of the actuarial value calculator for "multi-tier networks";
- ARSD 20:06:58:19 – imposes special rule for plans utilizing multiple tiers of prescription drug benefits;
- ARSD 20:06:58:20 – imposes special rule for plans utilizing multiple network tiers;
- ARSD 20:06:58:24 – identifies nonquantitative treatment limitations that apply to plans with multiple network tiers "such as preferred providers and participating providers."

Nothing in the AWP Law changes these statutes and regulations, or alters the fact that the Insurance Code expressly allows for closed-network (focused) plans and tiered (preferred-provider) plans. Nevertheless, the circuit court's decision would require judicial repeal of these statutes by rendering "closed" plans illegal under the AWP Law. For example, although section 58-17F-11(7) entitles health insurers to terminate provider contracts without cause upon timely written notice, the circuit court's declaration bars a health insurer from limiting participation in focused plans for providers

who meets the criteria in the statute. (R. 1271.) This effectively repeals the rights granted to health insurers under section 58-17F-11(7). In addition, extending the scope of the AWP Law to tiered plans like Sanford PLUS would nullify the statutes and regulations related to tiered and preferred provider plans.

The circuit court attempted to harmonize its interpretation of the AWP Law with these statutes by reasoning that "'closure' conditions can still exist but be limited as to geographic location and acceptance of reimbursement rates." (R. 1273.) This distinction finds no support in the record. More importantly, this distinction is meaningless because *even open plans* can be limited based on geographic location and acceptance of reimbursement rates. Indeed, the distinguishing feature between open and closed plans is a health insurer's ability to create plans to meet the circumstances of a diverse population with different health insurance needs and priorities, which is exactly what the court's declaration eliminates.[4] The manner in which these

[4] Plaintiffs argued below that a "closed plan" is not one that allows insurers to exclude providers, but rather is one that doesn't provide benefits for out-of-network services. (R. 1154.) This argument is the tail wagging the dog. The definition of "closed plan" is a plan in which a health insurer "requires covered persons to use participating providers" and, as a result, "does not provide any benefits for out-of-network services except for emergency services." SDCL 58-17F-1(1); SDCL 58-17G-1(1); SDCL 58-17I-1(8). The reason closed plans provide no benefits for out-of-network services is because South Dakota law allows insurers to exclude providers, and to direct patients to only those providers who are in-network.

plans are created necessarily includes the need to create efficiencies through provider selection. Accordingly, the circuit court's decision does not actually harmonize the many provisions of the South Dakota Insurance Code that expressly authorize closed-network plans *that allow for exclusion* of certain providers. *See, e.g.*, SDCL 58-18A-64 ("Under the terms of a closed panel plan, no benefits are payable if the covered person does not use the services of a closed panel provider.") Therefore, the circuit court's declaration cannot avoid implied repeal.

Even if the circuit court's distinction between closed and open plans was meaningful, at least one of the provisions would still be subject to implied repeal. *See* SDCL 58-17F-11(7) ("The health carrier and participating provider shall provide at least sixty days written notice to each other before terminating the contract without cause.") The circuit court offers no explanation for why this provision would not be subject to implied repeal. Consequently, the presumption against implied repeal cannot be avoided.

The circuit court, however, failed to correctly analyze the presumption, not only by creating a false distinction between open and closed plans, but also by shifting the duty to harmonize facially conflicting laws—a judicial function—to the Legislature. (R. 1273 ("[I]f ambiguity

exists, it is a matter of clarification for the legislature.").) *See Karlen*, 339 N.W.2d at 323 (harmonizing conflicting statutes is court's responsibility).

Applying this Court's admonition, any doubt about the meaning of the statute must be resolved in SHP's favor because only SHP's interpretation harmonizes the AWP Law with the rest of the Insurance Code. There is no "manifest necessity" to adopt Plaintiffs' interpretation on a record that is devoid of any evidence showing that South Dakota voters intended Initiated Measure 17 to repeal numerous provisions of the Insurance Code—or to undermine the statutory basis for operation of HMOs in South Dakota. *See Faircloth*, 2000 S.D. 158, ¶ 10, 620 N.W.2d at 202 ("Judges should refrain from negating a legislative act unless it is demanded by manifest necessity . . . [and] the Legislature's intent to do so must be apparent."). Therefore, the circuit court erred by adopting Plaintiffs' interpretation.

The circuit court also mistakenly concluded that references to "panel" or "panel of providers" in a plan-specific context in other statutes support a plan-specific reading in the AWP Law. (*See* R. 1272.) Specifically, the court relied on two statutes defining or referencing a "closed panel plan" in other provisions in the South Dakota Insurance Code as evidence that the AWP Law contemplates a "panel of providers" for each plan. (*Id.* (discussing SDCL 58-18A-53(3) (defining "closed panel plan") and SDCL 58-18A-64

("Under the terms of a closed panel plan, no benefits are payable if the covered person does not use the services of a closed panel provider.")).) The fact that these statutes use language that is expressly plan-specific is precisely why the AWP Law must be interpreted differently; the AWP Law drafters knew how to compose plan-specific language, but they chose not to do so. *See Steinberg*, 2000 S.D. 36, ¶ 10, 607 N.W.2d 596, 600; *Stanton*, 1996 S.D. 109, ¶¶ 1, 11, 553 N.W.2d at 795.

IX. A Plan-Specific Interpretation Thwarts the Express Purpose of the AWP Law.

Although discovery of legislative (or voter) intent must *begin* with the language of the statute itself, *State v. Bryant*, 2020 S.D. 49, ¶ 20, 948 N.W.2d 333, 338, a court must also consider the purpose of a statute in order to avoid interpretations that would "functionally annul" the law. *See Steinberg*, 2000 S.D. 36, ¶ 15, 607 N.W.2d at 601-02 ("When one interpretation 'would functionally annul the law, the cardinal purpose of statutory construction – ascertaining legislative intent – ought not be limited to simply reading a statute's bare language; [a court] *must also reflect upon the purpose of the enactment*; the matter sought to be corrected and the goal to be attained.'" (emphasis added).) In addition, this Court often looks to "sound public policy" to confirm its interpretation of a statute or initiated

measure. *SDDS, Inc. v. State*, 481 N.W.2d 270, 272 (S.D. 1992) (initiated measure); *Stanton*, 1996 S.D. 109, ¶ 12, 553 N.W.2d at 795 (statute).

The purpose of the AWP law is written into the statute itself: patient choice in the selection of healthcare providers.

> 58-17J-2. *Patient choice*—Health care provider participation.
>
> *No health insurer*, including the South Dakota Medicaid program, *may obstruct patient choice* by excluding a health care provider licensed under the laws of this state from participating on the health insurer's panel of providers if the provider is located within the geographic coverage area of the health benefit plan and is willing and fully qualified to meet the terms and conditions of participation as established by the health insurer.

SDCL 58-17J-2 (emphasis added).

Only SHP's interpretation fulfills this statutory purpose. SHP has a single panel of providers that is open to any willing provider, including Plaintiffs. (R. 513 (¶¶ 20, 22); *see* R. 530.) Individuals and businesses have the option of purchasing a broad plan, which allows patients to choose any provider on SHP's entire panel of providers and to have that care covered by insurance. (R. 514-16 (¶¶ 27, 29); *see* R. 531, 210, 226.) Any employer who offers an SHP focused plan to its employees must also offer at least one broad plan. (R. 516-17 (¶¶ 39-40); *see* R. 531-32, 191, 691.) Thus, every patient with an SHP plan has the option to purchase a plan that gives them in-network access to SHP's entire panel of providers, including Plaintiffs. Plaintiffs concede these points. (R. 518 (¶ 48); *see* R. 1064 (admitting that

any patient who has an SHP insurance plan has the option to see Plaintiff and have care covered by insurance), 988 (similar), 1005 (similar).)

Recognizing that broad plans do not fit the budgets or healthcare needs of all South Dakotans, SHP gives patients an *additional* option. Patients can choose a focused plan that utilizes a subset of SHP's entire panel of providers and is more affordable. (R. 516 (¶ 33); *see* R. 528, 531.) Accordingly, South Dakotans who have no need to access SHP's full panel of providers or who would otherwise be priced-out of the more expensive broad plans—and potentially be denied any health insurance or any ability to choose their provider—have a health insurance option that gives them access to quality care from a more narrowly tailored network of providers. (R. 516 (¶ 33); *see* R. 531, 528; *see also* R. 584 (admission by Plaintiff Orthopedic Institute that it is "important for patients to have affordable healthcare options"), 1051 (same admission by Plaintiff Ophthalmology Ltd.).)

If SHP is required to include all providers in focused plans like TRUE or Tier 1 of PLUS, the cost of operating those plans will increase. (R. 532 (¶ 25).) For example, the number of claims processed and paid within those plans would likely increase significantly, causing the cost to operate those plans to increase. (R. 529-30 (¶ 8).) Numerous efficiencies related to patient care coordination, pre-authorization and claims processing, medical record

retrieval, and more would be lost. (R. 1212-14 (¶¶ 3-11); *see* R. 529-30 (¶¶ 6-8).) And SHP's ability to negotiate lower reimbursement rates will be diminished. (R. 529 (¶ 6), 1212 (¶ 3).)

Consequently, SHP's costs to maintain focused network plans will increase significantly—making the plans more expensive for patients—or, the plans will be so economically unsustainable that they will need to be eliminated. (R. 519 (¶ 49); *see* R. 529-30, 532, 1214.) This will leave patients with *fewer choices* for health care providers than they currently have, as even Plaintiffs admit. (R. 519 (¶ 51) (admission that eliminating narrow networks means "eliminating a choice of the consumer to choose a lower cost option for [patient] needs"); *see* R. 630, 532.) South Dakotans who are priced out of health insurance will lose any freedom to choose their provider. (R. 532 (¶¶ 25-26).)

The circuit court failed to address any of this evidence, *which remains unrebutted*. Instead, the court dismissed issues of affordability and plan options as "complex collateral matters" outside the purpose of the statute. (R. 1270-71; *see* R. 1273 (rejecting SHP's interpretation as "conflat[ing]" the purpose of the statute).) This is incorrect. Plaintiffs' position, adopted below, rests on a mistaken premise: that choosing one's doctor is divorced from choosing one's health insurance plan. In reality, which doctor a patient

chooses is intimately tied to what sort of health insurance the patient has or needs. The AWP Law recognizes this, by expressly tying its goal of "patient choice" to *health insurance*—and by requiring that providers/doctors be able to participate in a "*health insurer's* panel of providers." SDCL 58-17J-2 (emphasis added).

Access to affordable health plans is essential to the AWP Law's workings and purpose: the law promotes patient choice through a panel of providers, which patients access through health insurance plans. (R. 642 ("With health insurance coverage, you have access to quality care through a network of health care providers.").) Without affordable health insurance plans, many South Dakotans will lose any meaningful choice of provider.[5] This would "functionally annul" the cardinal purpose of the AWP law, *Steinberg*, 2000 S.D. 36, ¶ 15, 607 N.W.2d at 601-02, is contrary to "sound

[5] For this reason, the circuit court also erred in concluding that the "difference in the parties' arguments comes down to what patients have a right to choose – a provider or a plan." (R. 1270.) Even under Plaintiffs' interpretation, patients must choose a plan before they can choose a provider. Once a patient chooses a plan, the patient can see any provider who is in-network with their plan to receive network benefits. (R. 514-15 (¶¶ 27-29).) There is no difference between broad and focused plans in this regard. (*Id.*; R. 215, 531-32 (¶¶ 14, 21-22).) The difference between the parties' position is that while SHP's position maintains broad and focused options for patients, Plaintiffs' interpretation—adopted by the circuit court—will remove lower cost options and eliminate patient choice for South Dakotans who can no longer afford health insurance.

public policy," *SDDS*, 481 N.W.2d at 272, and harms South Dakota patients. Accordingly, the circuit court's interpretation should be rejected.

X. Because Plaintiffs Belong to SHP's Panel of Providers, SHP Complies With the AWP Law and Is Entitled to Summary Judgment.

Under a proper reading of the AWP Law, a health insurer must maintain only a single panel of providers that is open to any provider who meets the conditions in the statute. The unrebutted record shows that SHP fulfills this requirement. SHP has a panel of providers consisting of every provider located in the geographic coverage areas of any SHP health benefit plan who has met and agreed to be bound by terms and conditions that SHP establishes to join the panel. (R. 513 (¶ 20); *see* R. 530.) Every Plaintiff in this case is on SHP's panel of providers, and each Plaintiff has separate contracts by which they participate in the Sanford Signature Plan, the Sanford Simplicity Series Plan, and the Sanford PLUS Plan. (R. 513-14 (¶¶ 22-23); *see* R. 530, 705-06, 718, 728, 739-40.) Accordingly, the Court should reverse the circuit court's decision and direct the circuit court to enter judgment for SHP.[6]

[6] If the Court agrees with SHP's interpretation of the AWP Law, the Court's analysis can stop here. The decision of the circuit court should be reversed, and the Court should direct the circuit court to enter judgment in favor of SHP. Otherwise, the decision of the circuit court should be reversed for the additional reason explained *infra*, Argument II.

XI. The Circuit Court Erred in Finding No Genuine Issue of Material Fact Exists Regarding Plaintiffs' Willingness to Accept SHP's Terms and Conditions.

If the Court determines that the circuit court was correct that the panel of providers in the AWP Law is plan-specific, the circuit court still erred when it found that there was "no genuine dispute of material fact regarding Plaintiffs' qualifications and willingness to accept SHP's terms." (R. 1267.) The undisputed record shows that *there is a genuine issue of material fact* regarding Plaintiffs' willingness to accept the terms and conditions of participating in SHP's plans.

In making its determination—a legal conclusion subject to *de novo* review—the circuit court relied solely on a representation by Plaintiffs' counsel that Plaintiffs were willing to meet all the terms and conditions of a contract that SHP entered with Sanford Health.[7] (R. 1158; *see* R. 233-92.) The circuit court relied heavily on this representation and identified no other support in the record for its conclusion. (*See* R. 1267-68 ("Plaintiffs are willing to meet the terms and conditions of participation, as Plaintiffs' attorney reviewed the terms of the contract between SHP and Sanford Health and expressed Plaintiffs' willingness to meet the terms and conditions of the

[7] As noted *supra* at 7, SHP's terms and conditions include both credentialing requirements and contractual terms. *See* ARSD 20:06:56:14 (requiring health insurers to develop "selection standards" for providers consistent with statutory requirements). Plaintiffs' qualifications for credentialing purposes are not in dispute because Plaintiffs are already credentialed to be on SHP's panel of providers and are in-network for SHP's Signature, Simplicity, and PLUS plans. (R. 1268.)

contract.").) The circuit court's conclusion was erroneous because record evidence contradicts, rather than supports, the self-serving representation of Plaintiffs' counsel. *See Pessima v. Allen*, 2021 WL 1691143, at *5 (D.S.D. Apr. 29, 2021) ("[I]t is black letter summary judgment law that a conclusory, self-serving affidavit will not defeat an otherwise meritorious summary judgment motion."); *Frevert v. Ford Motor Co.*, 614 F.3d 466, 473-74 (8th Cir. 2010) (self-serving affidavit that contradicted prior representations by plaintiff was not sufficient to avoid summary judgment in favor of defendant).

First, unrebutted evidence shows that the terms and conditions for participating in a health benefit plan are negotiated individually and vary between providers. (R. 531 (¶ 14).). Even where the same reimbursement methodology is used, the reimbursement rates for providers may differ. For example, a full-service hospital (like a Sanford Health facility) typically receives higher reimbursement rates than a specialty hospital (like Plaintiff SFSH) because a full-service hospital offers not only what are typically profitable services—like surgical and procedural care—but also less or non-profitable services like 24-hour emergency care, trauma care, neonatal intensive care, and more. (R. 1215 (¶¶ 14-16).) The current terms and conditions agreed to between SHP and Sanford Health, including

reimbursement rates, are not the same terms and conditions that would be offered to Plaintiffs, which are not full-service hospitals. (*See id.*) There is no evidence in the record that the terms and conditions contained in a contract between SHP and Sanford Health would be the same as the terms and conditions contained in a contract between SHP and any of the Plaintiffs. (*See generally* R. 233-92.) In fact, the undisputed record shows that the terms very likely would *not* be the same.[8] (*See* R. 531 (¶ 14), 1215 (¶¶ 14-16).) As a result, an assurance from Plaintiffs' lawyer that his clients would abide by certain contractual terms—when the record contains no evidence that his clients would be offered those terms and conditions—cannot support summary judgment for Plaintiffs.

Second, the corporate representative for Plaintiff Ophthalmology Ltd., Stan Gebhart, testified during his deposition that he could not predict all the terms, conditions, or other contractual provisions that SHP might request during such contract negotiations, and that some of these would be "deal breakers" that would prevent Ophthalmology Ltd. from agreeing to become in-network for certain SHP plans. (R. 522 (¶¶ 63-64); *see* R. 1064-65.) The circuit court ignored this testimony, which directly contradicts Plaintiffs'

[8] Moreover, nothing in the AWP law requires health insurers to offer the same terms and conditions to every provider.

lawyer declaration. In the face of this evidence, the statements of Plaintiffs' counsel cannot support summary judgment. *See Frevert*, 614 F.3d at 473-74; *Mountain Peaks Fin. Servs., Inc. v. Roth-Steffen*, 778 N.W.2d 380, 388 (Minn. App. 2010) (self-serving affidavit that contradicted other record testimony was not enough to avoid summary judgment).

* * *

The record is devoid of evidence that Plaintiffs would be offered the same terms and conditions as those contained in the contract that Plaintiffs' attorney references in his affidavit. In fact, the undisputed record contains evidence that in any yet-to-be-negotiated contract between SHP and Plaintiffs, the terms and conditions would not be the same, and nothing in the AWP law requires them to be the same. The undisputed record also shows that at least one Plaintiff testified to certain terms and conditions that it *would not be willing to accept*. Therefore, there is a genuine issue of material fact as to whether the Plaintiffs would accept the terms and conditions of SHP's focused plans, and the circuit court erred in granting summary judgment to Plaintiffs. *See Fisher*, 2002 S.D. 30, ¶ 11, 641 N.W.2d at 127 (reversing erroneous grant of summary judgment where issues of fact remained). The decision of the circuit court should be reversed.

CONCLUSION

Plaintiff's interpretation of the AWP Law, erroneously adopted by the circuit court, impermissibly re-writes the AWP law, violates this Court's strong admonition against the implied repeal of at least ten South Dakota statutes and numerous regulations, and violates the AWP law's express purpose. Sanford Health Plan respectfully asks the Court to reverse the decision of the circuit court, and direct the circuit court to enter judgment in favor of SHP.

Dated at Sioux Falls, South Dakota, this 27th day of July, 2023.

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CERTIFICATE OF COMPLIANCE

The undersigned hereby certifies that the Brief of Appellant Sanford Health Plan complies with the type volume limitations set forth in SDCL 15-26A-66(b)(2). Based on the information provided by Microsoft Word 2016, this Brief contains 8,990 words, excluding the Table of Contents, Table of Authorities, Jurisdiction Statement, Statement of Legal Issues, any addendum materials, and any Certificates of counsel. This Brief is typeset in Times New Roman (12 point) and was prepared using Microsoft Word 2016.

Dated at Sioux Falls, South Dakota, this 27th day of February 2023.

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IN THE SUPREME COURT
OF THE
STATE OF SOUTH DAKOTA

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The undersigned, one of the attorneys for Appellant Sanford Health Plan, Inc., hereby certifies that the "Brief of Appellant Sanford Health Plan, Inc." and "Appendix of Appellant Sanford Health Plan, Inc." were filed

electronically with the South Dakota Supreme Court through Odyssey File & Serve and that the original was filed by mailing the same to 500 East Capitol Avenue, Pierre, South Dakota 57501-5070, on February 27, 2023.

The undersigned further certifies that an electronic copy of the "Brief of Appellant Sanford Health Plan, Inc." and "Appendix of Appellant Sanford Health Plan, Inc." were served via Odyssey File & Serve to the attorneys set forth below on February 27, 2023:

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Dated at Sioux Falls, South Dakota, this 27th day of July, 2023.

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Sanford Health Plan, Inc.'s Statement of Undisputed Material Facts in Support of its Motion for Summary Judgment (R. 509-524) is not included in the Appendix pursuant to SDCL § 15-26A-60(8)(b) as it was filed as Confidential

Sanford Health Plan, Inc.'s Response to Plaintiffs' Statement of Undisputed Material Facts (R. 1238-1256) is not included in the Appendix pursuant to SDCL § 15-26A-60(8)(b) as it was filed as Confidential

IN THE SUPREME COURT
OF THE
STATE OF SOUTH DAKOTA

Appeal No. 30207

ORTHOPEDIC INSTITUTE, P.C.; SIOUX FALLS SPECIALTY HOSPITAL, L.L.P.; SIOUX FALLS SPECIALTY HOSPITAL, L.L.P. D/B/A SIOUX FALLS URGENT CARE; SIOUX FALLS SPECIALTY HOSPITAL, L.L.P. D/B/A WORKFORCE OCCUPATIONAL HEALTH AND MEDICAL SERVICES; SIOUX FALLS SPECIALTY HOSPITAL, L.L.P. D/B/A MIDWEST PAIN SPECIALISTS; SIOUX FALLS SPECIALTY HOSPITAL, L.L.P. D/B/A MIDWEST IMAGING; OPHTHALMOLOGY LTD., INC.; and OPHTHALMOLOGY LTD. EYE SURGERY CENTER, L.L.C.,

Plaintiffs and Appellees,

v.

SANFORD HEALTH PLAN, INC.,

Defendant and Appellant.

Appeal from the Circuit Court, Second Judicial Circuit
Minnehaha County, South Dakota

The Honorable Rachel R. Rasmussen
Circuit Court Judge

BRIEF FOR AVERA HEALTH PLANS, INC. AS AMICUS CURIAE IN SUPPORT OF APPELLANT

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PRELIMINARY STATEMENT

This Brief for Avera Health Plans, Inc. ("AHP") as Amicus Curiae is being filed in accordance with the permission granted by this Court's Order Granting Motion for Leave to File Amicus Curiae Brief dated March 13, 2023. AHP's Brief supports Defendant and Appellant, Sanford Health Plan, Inc., ("SHP").

In this Brief, references made to Plaintiffs/Appellees shall be made to "Appellees." But for in FN7 below, there will be no references to the Circuit Court Record as much of it is sealed. The Circuit Court's Memorandum Opinion Granting Plaintiffs' Motion for Summary Judgment and Denying Defendant's Motion for Summary Judgment, dated December 2, 2022, shall be referred to herein as "the Circuit Court's Decision."

References to the Brief of Appellant SHP, filed on February 27, 2023, shall be to "SHP's Brief Pg. ____." References to the Appendix of SHP's Brief shall be made to "SHP's Append. Pg. _____."

To the extent SDCL 15-26A-60 is deemed applicable to this Brief, AHP adopts and incorporates by reference the jurisdictional statement, statement of legal issues, and statement of the case and facts set forth in SHP's Brief.

STATEMENT OF INTEREST

AHP is a South Dakota 501(c)(4) corporation, organized and operated exclusively for the not-for-profit purpose of the promotion of social welfare within the meaning of Section 501(c)(4) of the Internal Revenue Code. This includes furthering the tax-exempt, charitable purposes of its sole shareholder, Avera Health, a South Dakota 501(c)(3) corporation. Such activities encompass, but are not limited to, improving the health of

the community served by AHP and Avera Health through developing and operating health care delivery plans and financing systems, providing and arranging for the provision of health care and related services, implementing programs intended to improve the quality and affordability of health care, and creating programs intended to increase access to quality health care. No part of AHP's net earnings, gains, or assets inure to the benefit of, or are distributable to any director or officer of the corporation, or to any private individual.

AHP has a Certificate of Authority from the South Dakota Division of Insurance to offer health benefit plans in South Dakota. Per the Division of Insurance's Market Share Reports,[1] from 2019-2021, the market share for the "Health" category of insurance in South Dakota indicated that behind Wellmark of South Dakota, Inc., AHP was the second largest provider of health insurance in South Dakota with a 16.6% market share in 2021, 16.2% in 2020, and 15.3% in 2019.

AHP is interested in this matter as an affirmance will adversely impact the health insurance market for both health insurance providers and consumers in South Dakota. AHP appreciates this opportunity to be heard in support of SHP.

SUMMARY OF ARGUMENT[2]

Many any willing provider ("AWP") laws increase the number of providers from whom an insured can receive covered treatment, however, these laws often restrict

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[1] Available at: https://dlr.sd.gov/insurance/market_share.aspx

[2] AHP's support of SHP is directed toward Issue 1 from SHP's Brief, Pg. 1-2. AHP takes no position on Issue 2 as it appears there are underlying factual disputes. Specifically, if SHP's narrow or tiered plans have to be opened up to Appellees, fact issues exist as to whether or not the yet to be determined terms that would be offered by SHP to Appellees would be acceptable.

patient choice by eliminating lower priced plan options from the market. To balance the competing interests of provider choice versus cost savings, and unlike other broad AWP laws they could have used as a model, the drafters of SDCL 58-17J-2 created a narrowly tailored and flexible AWP law that only required an insurer to open its overall panel of providers to willing providers, not every one of its plans. Consequently, South Dakota health insurers were left with the ability to provide South Dakotans choices between: 1) Plan options that prioritize patient choice in providers, regardless of which insurer issues the plan; or 2) Plan options at lower price points with more limited networks of providers. This is exactly what voters were promised when the advocates for SDCL 58-17J-2 pledged that lower prices and increased provider options could be delivered under their proposal.

In response to the enactment of SDCL 58-17J-2, SHP balanced these two competing interests with the at-issue plan offerings and sales model which comply with the letter and intent of SDCL 58-17J-2. In doing so, SHP furthered important state interests in affordable and available quality health care and harmonized SDCL 58-17J-2 with numerous South Dakota insurance statutes and rules contemplating the sale of insurance in a closed-network form.

The Circuit Court should be reversed. Correctly doing so, and granting SHP's cross-motion for summary judgment, will confirm that SDCL 58-17J-2 truly allows what South Dakota's voters were promised. In contrast, an affirmance would restrict patient choice, leaving only more expensive plan options in the market.

ARGUMENT

I. Broad Any Willing Provider Laws Drive up the Cost of Health Insurance

Broad AWP laws increase health insurance costs. While there are numerous reasons for this,[3] a key cause was aptly described by the U.S. Supreme Court in a 2003 case addressing an ERISA challenge to an AWP law: "Kentucky's AWP statutes impair the petitioners' ability to limit the number of providers with access to their networks, and thus their ability to use the assurance of high patient volume as the *quid pro quo* for the discounted rates that network membership entails." *Kentucky Ass'n of Health Plans, Inc., v. Miller*, 538 U.S. 329, 332 (2003). These "discounted rates" that providers are willing to accept for the assurance of a limited network reduces insurer costs thereby allowing insurers to reduce premiums.[4]

In the decade preceding the *Kentucky* case, managed care products became the preferred model for insurers who were trying to find ways to control exponentially rising health care costs. Sharon Reece, *Puncturing the Funnell - - Saving the "Any Willing Provider" Statutes from ERISA Preemption*, 27 U.Ark. Little Rock L. Rev. 407, 407 and 409 (2005) (citations omitted). Through Health Maintenance Organizations ("HMOs"), and other similar models, costs could be saved through, among other things, restricting provider networks to decrease reimbursement rates and by allowing for greater insurer oversight to address quality and perceived over-treatment. Id. at 411-412. Opponents of

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[3] FN9 below discusses these reasons.

[4] Setting premiums is a complicated process. Insurers must set premiums based upon numerous variables and utilizing the assistance of actuaries, with the goal being to put forth a competitive product in the market that also has an acceptable medical loss ratio allowing the plan to remain sustainable. Premiums for some offerings also must be approved by the South Dakota Division of Insurance.

AWP laws who favored narrow network models argued that administrative costs are lower when insurers can create narrower networks, citing studies that concluded administrative costs could increase from 34% to 52% with the introduction of AWP laws. Id. at 419 (citations omitted).

In response, groups of independent providers sought to protect their favored fee-for-service model by lobbying for AWP laws. Without such protection, these providers would have to compete in price and other terms and conditions with other provider groups to get into narrow networks, or they would need to become otherwise affiliated with such networks. See, Id. at 411 (providing two examples of the manner in which providers could become affiliated with HMOs). These independent groups claimed that without AWP laws, patient choice in providers would be restricted and burdensome travel would be required of patients to visit distant in-network providers. Id. at 412. They also generally argued that the managed care model restrained trade. Id.

With health care cost being a national topic of concern, considerable literature exists debating the efficacy of AWP laws. The literature runs largely from the mid-1990s through present, much of it preceding the *Kentucky* case or addressing the *Kentucky* case itself. Some of the early literature went back and forth on the cost impact of AWP laws, however, the most noteworthy analysis pertaining to the cost of broad AWP laws is found in a 2014 letter sent from the Federal Trade Commission ("FTC") to the Center for Medicare & Medicaid Services ("CMS"). United States of America Fed. Trade Comm'n, Office of Policy Planning, Bureau of Econ., Bureau of Competition, Opinion Letter Re: Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the

Medicare Prescription Drug Benefit Programs (Mar. 7, 2014).[5] This letter, referred to herein as the "FTC Letter," was provided in response to the CMS's request for comment upon its 2015 proposals.

The FTC Letter, which focused almost exclusively on the AWP concept, is noteworthy because of who it was from, its timing in post-dating some of the early un-settled analysis on the cost impact of AWP laws, and because it pulled together a number of studies and other resources on this topic. Ultimately, the FTC Letter made the case that broad AWP laws have an adverse impact on the cost of both health insurance and overall health care. Starting at Pg. 3, the FTC Letter surmised:

> If plans cannot give providers any assurance of favorable treatment or greater volume in exchange for lower prices, then the incentive for providers to bid aggressively for the plan's business – by offering better rates – is undermined. At the same time, any willing provider and FOC[6] provisions may also reduce incentives for plans to invest in plan designs and complex negotiations with pharmacies and manufacturers. Any willing provider and FOC provisions can therefore undermine the ability of plans to reduce costs. This is likely to result in higher negotiated prices, ultimately harming consumers. Any willing provider and FOC laws can also limit competition by restricting the ability of insurance companies to offer consumers different plans, with varying levels of coverage, cost, and choice. These restrictions on competition may result in insurance companies paying higher fees to providers, which generally lead to higher premiums, and may increase the number of people without coverage.

Id. at Pg. 3 (internal citations omitted). At Pg. 5-6, the Letter went on to support its position by discussing multiple studies. It explained in one study that the "Connecticut health plans' ability to negotiate discounts with hospitals increased with the plan's

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[5] Accessible at: https://www.ftc.gov/system/files/documents/advocacy_documents/federal-trade-commission-staff-comment-centers-medicare-medicaid-services-regarding-proposed-rule/140310cmscomment.pdf

[6] FOC refers to "Freedom of Choice."

willingness and/or ability to channel patients to selected hospitals, consistent with the predictions of a theoretical model introduced in the same study." Id. at Pg. 5 (citing Alan T. Sorensen, Insurer-Hospital Bargaining: Negotiated Discounts in Post-Deregulation Connecticut, 51 J. INDUS. ECON. 469 (2003)). It noted, in a second study, "that Massachusetts health plans willing to be more selective in forming their hospital networks obtained deeper discounts." Id. (citing Vivian Y. Wu, Managed Care's Price Bargaining with Hospitals, 28 J. HEALTH ECON. 350 (2009)).

The FTC Letter continued by describing two additional peer-reviewed studies analyzing state-by-state policy variations to measure the effects of broad AWP laws, plus it referenced a working paper upon which it relied:

> Research performed and published by an FTC economist has found, for example, that any willing provider laws generally undermine the ability of managed care organizations to lower health care spending. Specifically, the study found that per capita total health care expenditures are higher in states with any willing provider laws. A 2009 study similarly examined variations in state any willing provider laws applicable to drug purchases to measure their effects. It found that states with any willing provider laws have higher prescription drug spending than those without them. The conclusion was the same, even when using different econometric techniques to account for variations across the states, such as differences in demographics, market structure, and regulatory environment. Finally, a more recent working paper examined state-level per capita health expenditure data from CMS and found that any willing provider and FOC laws are associated with four percent higher per-capita drug expenditures.

Id. at 6 (citing Michael G. Vita, Regulatory Restrictions on Selective Contracting: An Empirical Analysis of `Any-Willing Provider' Regulations, 20 J. HEALTH ECON. 955 (2001); Christine Piette Durrance, The Impact of Pharmacy-Specific Any-Willing-Provider Legislation on Prescription Drug Expenditures, 37 ATLANTIC ECON. J. 409 (2009); Jonathan Klick & Joshua D. Wright, The Effect of Any Willing Provider and

Freedom of Choice Laws on Health Care Expenditures, U. Penn. Inst. for Law & Econ. Res. Paper No. 12-39 (Feb. 24, 2014)).

Since the FTC's 2014 letter, the AWP concept has retained the attention of industry experts as they continue to strategize on how to lower health care costs. For example, in April of 2017, Martin Gaynor, Farzad Mostashari, and Paul Ginsburg published a white paper entitled: "Making Health Care Markets Work: Competition Policy for Health Care; Actionable Policy Proposals for the Executive Branch, Congress, and the States" (Referred to herein as "the Gaynor Paper").[7] In their analysis, these experts noted: "[r]esearch shows the AWP laws increase health care costs." (Gaynor Paper, Pg. 24). Consistent with the traditional open market beliefs often espoused in South Dakota, the Gaynor Paper reasoned: "[i]f consumers desire broader networks that include more providers and are willing to pay for them, then a well-functioning insurance market will provide consumers that choice. Similarly, consumers who are not willing to pay for broader provider choice should be allowed to select plans that cost less and have narrower networks." (Id.)

Broad AWP laws increase the cost of health insurance. Fortunately for South Dakota's citizens, SDCL 58-17J-2 is a narrow version of the traditional, broad AWP concept.

II. SHP's Plans Comply with South Dakota's Narrow AWP Law

Historically, health insurers in South Dakota, subject to network adequacy requirements, had the ability to create managed care or similar models with narrow or

[7] Appellants' counsel confirmed the Gaynor Paper is in the Circuit Court's Record at Pg. 1170-1209.

closed networks by restricting access to their provider panels. South Dakota citizens with a paramount interest in low-cost health insurance benefited because the health plans' ability to fully restrict their provider panels resulted in lower premiums. Those citizens with group or employer health insurance options available from only one insurer who wanted greater provider choice were hindered under this prior model if the plan or plans offered them only contained a restricted or closed network.

To address the perception that South Dakotans desired more choice in providers, but still wanted affordable plan options, an initiated measure to enact an AWP law was sponsored in 2013. This measure was numbered Initiated Measure 17 ("IM17")). IM17 was narrowly tailored to only open up an insurer's overall panel of providers to willing providers, not every one of its plans. IM17 won at the ballot box and was later enacted as follows:

> **SDCL 58-17J-2. Patient choice - - Health care provider participation.** No health insurer, including the South Dakota Medicaid program, may obstruct patient choice by excluding a health care provider licensed under the laws of this state from participating on the health insurer's panel of providers if the provider is located within the geographic coverage area of the health benefit plan and is willing and fully qualified to meet the terms and conditions of participation as established by the health insurer.

Appellees wish to change and supplant this law, and the promises made by those who proposed it, by creating a broad AWP law that would require South Dakota's insurers to open up not just their panels, but every plan they offer. This would restrict patient choice and drive-up health insurance costs.

Germane to this analysis and supporting SHP's position is the other AWP laws available for reference preceding the drafting of IM17, the marketing campaign that sold IM17 to voters, the traditional statutory analysis of SDCL 58-17J-2, and the history in

South Dakota of legislative enactments permitting the use of closed network insurance plans. Individually, and collectively, these four points cut in favor of SHP's position.

A. The Drafters of IM17 Avoided a Broad AWP Law Meant to Protect Providers

The drafters of IM17 had numerous models to reference before coming up with the final version. The key for these drafters was to determine how broad or narrow the law should be based largely upon who it was intended to protect and at what cost.

The most pertinent reference available in drafting IM17 was from South Dakota. Long before 2013, South Dakota had a broad any willing pharmacist law. SDCL 58-18-37. This law, without distinguishing between an insurer's overall provider panel and its individual plans, required health insurers to allow any willing pharmacy or pharmacist the "right to participate as a participating provider for any policy or plan" offered by the insurer. SDCL 58-18-37(1). In accord with this law, insurers have to do more than open up their panels to willing pharmacists. Instead, they must permit inclusion in every plan they offer.

South Dakota's pharmacist law is akin to other broad AWP laws that can be found in states like Kentucky and Arkansas. Those states' AWP laws, which pre-dated IM17, do not recognize the provider panel versus health plan distinction, thereby requiring insurers to open every plan they offer to willing providers. For example, Kentucky's law disallows an insurer from discriminating against a provider by restricting access to its "health benefit plan[s]" from willing providers. Ky. Rev. State. Ann. § 304.17A-270. Similarly, Arkansas' AWP law "prohibits discrimination against a provider willing to meet the terms and conditions for participation established by a health insurer or that otherwise precludes an insurer from prohibiting or limiting participation

by a provider who is willing to accept a health insurer's terms and conditions for participation in the provision of *services through a health benefit plan.*" Ark. Code Ann. § 23-99-802(1) (emphasis added); See also, Ark. Cod. Ann. § 23-99-204(a) (appearing to restrict the ability of insurers in Arkansas to utilize tiered plan options). These broad AWP laws sacrifice the cost savings available through narrow networks to protect patient choice *and* to protect independent providers. Kentucky's law acknowledges this fact by its title: "Nondiscrimination *against provider* in geographic coverage area." Ky. Rev. State. Ann. § 304.17A-270 (emphasis added).

Alternatively, some states sought to allow insurers more ability to balance the competing interest of choice and cost by enacting narrower AWP laws. For example, Utah's AWP law opens up narrow networks in managed care plans to any willing provider, while still preserving an insurer's ability to reduce costs by utilizing narrow networks. Specifically, Utah insurers may utilize contract conditions that include "reasonable limitations on the number of designated network providers based upon substantial objective and economic grounds[.]" Utah Code Ann. § 31A-45-303(6)(a)(b)(ii). Similarly, in Georgia, certain types of HMOs are beyond the reach of its AWP laws, leaving them more ability to continue utilizing the narrow network concept. *Northeast Georgia Cancer Care, LLC v. Blue Cross and Blue Shield of Georgia, Inc.*, 726 S.E.2d 714, 721-23 (Ga. Ct. App., 2012).

The drafters of IM17 knew how to write a broad AWP law that would open up every plan an insurer offered to any willing provider. South Dakota had this exact type of broad law on its books already. Instead, they drafted and proposed a narrow AWP law focused on prioritizing patient choice but that preserved the insurers' ability to find ways

to continue minimizing plan costs through narrow network concepts. SHP's plans do precisely that.

B. South Dakota's Voters were Sold a Narrow AWP Law that Would Improve Patient Choice while Health Care Costs would be Lowered

The way in which IM17 was marketed to voters highlighted two key objectives: patient choice and lower cost. Regarding patient choice, IM17 was submitted: "FOR AN ACT ENTITLED, *An Act to ensure patient choice in the selection of health care providers*." Letter from Att'y Gen. of S.D. to S.D. Sec'y of St. Re: Health Care Provider Initiated Measure, (Aug. 12, 2013), Pg. 3 of 4, https://sdsos.gov/elections-voting/assets/PreferredProviderAGTitleAndExplanation.pdf. Prior to the voting on IM17, in the Ballot Questions document circulated by the South Dakota Secretary of State, proponents of IM17 stated, among other things, that "Patients deserve the freedom to choose their own doctor;" that IM17 "[a]llows families to see doctors and other medical providers they know and trust;" and it encouraged voters to "Vote Yes on IM-17 Patient Choice! You shouldn't have to change doctors if your job or insurance changes." 2014 Ballot Questions Publication, Issued by S.D. Sec'y of St. (2014), Pg. 4 of 6, https://sdsos.gov/elections-voting/assets/2014BQProConPamphlet.pdf.

Regarding the cost savings aspect, in the same Ballot Questions document, proponents of IM17 stated the law would "help control out-of-pocket costs and co-pays" and "Increase[] competition, helping control spiraling medical costs[.]" Id. They also

asserted: "And with out-of-pocket fees reduced or eliminated, patients will themselves spend less[.]"[8] Id.

Of note in these documents, the proponents of IM17 did not indicate they had proposed the measure to protect their interests whatsoever. Instead, they told voters that they "joined together to bring patients this freedom." Id.

In sum, voters were assured that while IM17 would increase choice, it would also provide for reduced health care costs. SHP's plans do precisely that.

C. SDCL 58-17J-2 and SHP's Compliant Plan Offerings, and the Way in Which those Plans are Offered, Strike the Balance the Voters Desired

For purposes of brevity, but for two critical points noted below, the full statutory analysis of SDCL 58-17J-2 and its applications to SHP's plans will not be fully restated here. SHP covered this issue at length in SHP's Brief at Pg. 14-17.

First, unlike the broad laws from other jurisdictions noted above, and unlike South Dakota's pre-existing any willing pharmacist law, SDCL 58-17J-2 expressly requires that each insurer allow any willing provider onto its "panel of providers." In contrast, South Dakota's pharmacy law states that an insurer must allow any willing pharmacist a "right to participate as a participating provider for any policy or plan" it offers. SDCL 58-18-37(1). The "panel of providers" language in SDCL 58-17J-2 is specific to the insurer, not the plan. This distinction is precisely what was necessary to

[8] The opponents of IM17 focused on costs based upon traditional AWP analysis like that noted above in Section I of this Brief. Any AWP law, narrow or broad, impacts insurer costs and the work insurers must do to attempt to contain those costs. Even with the narrow AWP law that was ultimately adopted in South Dakota, health insurers have been strained in spending time and resources to come up with new and compliant plan offerings and sales models.

give insurers latitude to provide plans that balance the competing concepts of broad patient choice with low cost health insurance.

Second, SDCL 58-17J-2 has a directive component which precedes the provider panel discussion: "No health insurer . . . may obstruct patient choice by excluding a health care provider . . . from [its] panel of providers[.]" Per this directive, insurers cannot use their overall panel of providers to obstruct patient choice. However, if their panel, and the plans available under their umbrella of offerings, do not obstruct patient choice, they are in compliance. This, again, gives insurers leeway to work underneath the open panel concept as long as the way in which their products are offered does not "obstruct patient" choice through the use of that panel.

Here, as described in SHP's Brief at Pg. 7-10, SHP has done exactly what was contemplated. It met the desires of South Dakota's voters while avoiding its use of the panel of providers framework to obstruct choice, ultimately providing consumers with more choice than they had before SDCL 58-17J-2. SHP did this by allowing any willing provider, including the Appellees, onto its panel of providers, and then creating differing plans underneath that overall panel. Some plans access the full panel. Others have narrower networks containing a limited set of the panel or creating tiered options from within the panel. The broad, full panel plans meet the call for increased patient choice. The narrow network and tiered plans satisfy the low-cost promise.

Ultimately, within the open market for purchasing insurance, SHP's plan offerings comply with SDCL 58-17J-2 on their face as they do not "obstruct patient choice" in any way. Every consumer in the open market is free to prioritize as they see

fit and select a plan that most benefits them. Unlike prior to SDCL 58-17J-2, these consumers can now access SHP plans covering any willing provider.

However, SHP did not stop here as there was still one issue of concern. Many South Dakotans only access health insurance through group or employer plans. If a group or employer only offered a SHP narrow network plan, this cross-section of the market would theoretically have patient choice "obstructed" (although these consumers could still make purchases on the open market). SHP's solution was to create a sales model by which any group or employer who wanted to offer SHP's narrow plans had to also offer a broad plan that included access to all providers on SHP's panel. This solution avoided conflict with the anti-obstruction directive or any other term of SDCL 58-17J-2. Alike those in the open market and unlike prior to SDCL 58-17J-2, every South Dakota employee or group member with a SHP option can now select a SHP plan that covers any willing provider. And, they can do so without having to go outside of the plan offerings provided by their group or employer – a specific selling point from IM17's proponents.

While not identical to SHP's plan offerings and methodology, AHP complies with the AWP law in a similar fashion through the use of its Traditional/Standard and Direct plans and the way those plans are offered to potential customers. (Aff. of Debra Muller, ¶4-5 (Filed with this Court on 2/6/23)). Like SHP, every South Dakota resident given the option to enroll into a 2023 AHP plan through his or her employer or group, and every South Dakota resident who considers an AHP plan in the open market, has the option to select an AHP plan with coverage for the entire panel of AHP's providers. (Id. at ¶5).

These open market consumers, employees, and group members all have access to AHP coverage with any willing provider.

As it was before 2014, it remains the narrow network concept that allows insurers to continue offering low-cost options to South Dakota citizens.[9] For example, a family of four, with two non-smoking parents aged 45 and two minor children seeking insurance quotes on the exchange in South Dakota for a 2023 AHP plan, would have an opportunity to choose from the broad Standard plan (including all providers on AHP's panel), or, if they lived in certain geographic areas, the narrow Direct plan. The Traditional AHP Standard 3500 Plan would have a premium 22.46% higher than the narrow AHP Direct 3500 Plan. (Aff. of Debra Muller, ¶7 (Filed with this Court on 2/6/23)).

SHP's plans, and SHP's methodology for selling them to groups or employers, enhance consumer choice. Consumers now have options to weigh what they value most – a plan with access to the most providers, including every Appellee in this case, or a plan with a more limited number of providers at a reduced cost. These consumers are getting exactly what they were promised.

[9] The reasons for an insurer's ability to save costs and therefore offer lower premiums for these narrower networks go beyond the fact that a narrow set of providers is willing to take less in reimbursement for inclusion in the narrow network. The FTC Letter discussed above explains some of these savings opportunities, including the efficiencies that can be created in narrower networks. SHP's Brief, at Pg. 9 and 26-27, mentioned similar reasons for such cost savings, including plan operation costs remaining low due to lower claim volume in narrow plans, plus efficiencies in care coordination, pre-authorization and claims processing, and medical record retrieval, that can be garnered through utilizing a narrow network. The Affidavit of Debra Muller, filed with this Court on 2/6/2023, at ¶6, echoed these points.

D. SHP's Plans and the Way in Which Those Plans are Offered Further Important State Interests and Harmonize SDCL 58-17J-2 with the Rest of South Dakota's Statutes and Rules Contemplating the Closed Network Concept

The desire to "preserv[e] and promot[e] adequate, available, and affordable medical care for [South Dakota] citizens" is an important state interest which this Court acknowledged long ago. *Knowles v. U.S.*, 1996 S.D. 10, ¶ 66, 544 N.W.2d 183, 197 (citations omitted). SHP's plan offerings further these important interests.

Moreover, South Dakota's statutes and rules have long recognized that insurers can further this interest by having the ability to create what the code often refers to as closed networks within insurance plan offerings. (See Numerous Laws and Rules in SHP's Append., Pg. 23 - 42). SHP's plans and interpretation of SDCL 58-17J-2 place it in harmony with these long-standing statutes and rules.

Appellees' confounding interpretation of SDCL 58-17J-2 not only undermines the state interests in promoting adequate, available, and affordable medical care, it makes many of South Dakota's closed network referencing statutes and rules nonsensical or void altogether. SHP fully analyzed this issue. See SHP's Brief at Pg. 18-24; See also, SHP's Append. at Pg. 23-42. Again, for purposes of brevity, SHP's full analysis is referenced here but will not be restated.

CONCLUSION

SDCL 58-17J-2 was voted into law to provide consumers greater provider choice with the assurance of lower cost health care. SHP has put forth a legally compliant product tailored to address exactly these directives.

The Circuit Court's Decision undermines patient choice and improperly restricts South Dakota's insurance market. It should be reversed. Doing so, and granting SHP's

cross-motion for summary judgment, will confirm that SDCL 58-17J-2 truly allows what South Dakota's voters requested when they passed IM17.

Dated this 6thday of April, 2023.

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CERTIFICATE OF COMPLIANCE WITH RULE 15-26A-66

I hereby certify that the foregoing Brief does not exceed the number of words permitted under SDCL 15-26A-66(b)(2), said Brief totaling 4597 words, which count excludes the Certificates and Signature blocks, as permitted by SDCL 15-26A-66(b)(3). I have relied on the word and character count of the word-processing system used to draft this Brief in preparing this certificate as permitted under SDCL 15-26A-66(b)(4).

Dated this 6th day of April, 2023.

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CERTIFICATE OF SERVICE

I, Matthew D. Murphy, do hereby certify that I am a member of Boyce Law Firm, L.L.P. attorneys for Amicus Curiae Avera Health Plans, Inc. and that on the 6th day of April, 2023, I served a true and correct copy of the within and foregoing Brief for Avera Health Plans, Inc. as Amicus Curiae in Support of Appellant via Odyssey file and served upon:

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IN THE SUPREME COURT
OF THE
STATE OF SOUTH DAKOTA

No. 30207

ORTHOPEDIC INSTITUTE, P.C.; SIOUX FALLS SPECIALTY HOSPITAL, L.L.P.; SIOUX FALLS SPECIALTY HOSPITAL, L.L.P. D/B/A SIOUX FALLS URGENT CARE; SIOUX FALLS SPECIALTY HOSPITAL, L.L.P. D/B/A WORKFORCE OCCUPATIONAL HEALTH AND MEDICAL SERVICES; SIOUX FALLS SPECIALTY HOSPITAL, L.L.P. D/B/A MIDWEST PAIN SPECIALISTS; SIOUX FALLS SPECIALTY HOSPITAL, L.L.P. D/B/A MIDWEST IMAGING; OPHTHALMOLOGY LTD., INC.; and OPHTHALMOLOGY LTD. EYE SURGERY CENTER, L.L.C.,

Plaintiffs and Appellees,

vs.

SANFORD HEALTH PLAN, INC.,

Defendant and Appellant,

Appeal from the Circuit Court
Second Judicial Circuit
Minnehaha County, South Dakota

THE HONORABLE RACHEL R. RASMUSSEN, Circuit Court Judge

APPELLEES' BRIEF

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Notice of Appeal of Defendant and Appellant filed December 29, 2022

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JURISDICTIONAL STATEMENT

The circuit court[1] granted the Plaintiffs'[2] Motion for Summary Judgment via a Memorandum Decision that was filed December 5, 2022, and an Order that was filed December 27, 2022. The Defendant, Sanford Health Plan ("SHP"), filed its Notice of Appeal on December 29, 2022. This Court has jurisdiction over this appeal pursuant to SDCL § 15-26A-3(1).

STATEMENT OF THE LEGAL ISSUES

1. Does the Any Willing Provider Law, codified at SDCL § 58-17J-2, allow a South Dakota health insurer to exclude a medical provider from participating in its health plans when the provider is located within the geographic coverage area of the plans and is willing and fully qualified to meet the insurer's terms and conditions for participating in the plans?

   No. The Any Willing Provider Law, like other any willing provider laws, impairs a health insurer's ability to limit the number of medical providers that can participate in its health plans. The purpose of any willing provider laws is to give patients the freedom to choose the medical provider with whom they treat. The circuit court applied the plain language of SDCL § 58-17J-2 to the undisputed material facts and concluded that SHP could not exclude the Plaintiffs from SHP's health plans at issue.

   SDCL § 58-17J-1
   SDCL § 58-17J-2

   In Re an Appeal by an Implicated Individual, 2021 S.D. 61, 966 N.W.2d 578 (*Implicated Individual I*)

   Prudential Ins. Co. of Am. v. Nat'l Park Med. Ctr., Inc., 413 F.3d 897 (8th Cir. 2005)

   Idaho Cardiology Assocs., P.A. v. Idaho Physicians Network, Inc., 108 P.3d 370 (Idaho 2005)

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[1] The Honorable Rachel Rasmussen of the Second Judicial Circuit.

[2] The Plaintiff physician groups are Orthopedic Institute, P.C., and Ophthalmology Ltd., Inc. ("Plaintiff physician groups"). The Plaintiff medical facilities are the Sioux Falls Specialty Hospital, L.L.P. including its urgent care, occupational health, pain, and imaging divisions, and Ophthalmology Ltd. Eye Surgery Center, L.L.C ("Plaintiff medical facilities").

2. Can SHP insist upon a protective order that only permitted the parties' attorneys and the circuit court to view the terms and conditions of the health plans at issue but then preclude summary judgment by claiming that a genuine issue of material fact exists as to whether the Plaintiffs are willing to accept those terms and conditions because the Plaintiffs have not had the opportunity to review them?

   No. SHP's attempt to create a genuine issue of material fact as to the Plaintiffs' willingness to meet the terms and conditions of SHP's health plans at issue is an attempt to use the protective order as both a shield and a sword. The Plaintiffs submitted affidavits setting forth that they would accept the terms and conditions of participating in the plans. Having reviewed the terms and conditions of the plans at issue, the Plaintiffs' attorney also had the legal authority to express the Plaintiffs' willingness to participate in such plans.

   SDCL § 16-18-11

   State ex rel. State Farm Mut. Auto. Ins. Co. v. Bedell, 719 S.E.2d 722 (W. Va. 2011)

   Fritsch v. City of Chula Vista, 187 F.R.D. 614 (S.D. Cal. 1999)

   Sony Computer Entm't Am., Inc. v. NASA Electronics, 249 F.R.D. 378 (S.D. Fla. 2008)

STATEMENT OF THE CASE

In 2014, an initiated measure was proposed to "ensure patient choice in the selection of health care providers." 2015 S.D. Sess. Laws ch. 278 (Initiated Measure 17). The initiated measure passed with over 60% of the vote.[3] The initiated measure was subsequently codified as SDCL § 58-17J-2, which provides:

> No health insurer, including the South Dakota Medicaid program, may obstruct patient choice by excluding a health care provider licensed under the laws of this state from participating on the health insurer's panel of providers if the provider is located within the geographic coverage area of the health benefit plan and is willing and fully qualified to meet the terms and conditions of participation as established by the health insurer.

SDCL § 58-17J-2 (the "AWP Law").

[3] South Dakota's 2014 election results are available online at https://sdsos.gov/elections-voting/assets/historicalelectiondata/2014GP.pdf (last visited May 16, 2023).

SHP is a taxable non-profit health insurer and a wholly-owned subsidiary of Sanford Health, a non-profit health system. SHP has created, maintained, and continues to maintain health benefit plans that restrict insureds to treating solely with medical providers employed by and facilities owned by SHP's parent, Sanford Health.

Notwithstanding the AWP Law, when non-Sanford Health providers and facilities request to participate in its closed health plans, SHP denies the providers' and facilities' requests. As a result, the insureds in SHP's closed plans are not permitted to treat with non-Sanford Health providers or at non-Sanford Health facilities unless they are willing to pay 100% out-of-pocket for treatment. This has resulted in non-Sanford Health providers having to turn away SHP insureds who could not afford to pay 100% out-of-pocket for medical treatment.

The Plaintiffs brought this action against SHP seeking a declaratory judgment that they meet the criteria in the AWP Law and, as a result, that SHP cannot exclude them from participating in SHP's closed plans. The Plaintiffs subsequently moved for summary judgment. SHP made a cross motion for summary judgment, arguing that because it included the Plaintiffs in some of its health plans, SHP could exclude the Plaintiffs from all other plans.

The circuit court entered summary judgment for the Plaintiffs. (App.[4] at 019–020; SR at 1275–76). The circuit court held that there were no genuine issues of material fact, as the Plaintiffs were all located within the geographic coverage area of SHP's health benefit plans at issue and were all willing and qualified to meet the terms and conditions of those plans. (App. at 012; SR at 1268). With respect to the interpretation

[4] Appellees' Appendix.

of the AWP Law, the circuit court held that SDCL § 58-17J-2's prohibition on excluding willing and qualified providers was plan specific, thus rejecting SHP's argument that it could satisfy the AWP Law by including the Plaintiffs on some plans but excluding the Plaintiffs from all other plans. (App. at 014–017; SR at 1270–73). This appeal followed.

FACTS

The Plaintiffs are independent physician groups and medical facilities[5] located in Sioux Falls, South Dakota. (App. at 021–022, 025, 030–031; SR at 397, 406–07, 410–11). All of the Plaintiffs' medical providers are licensed by the State Boards of Medical and Osteopathic Examiners, Optometry, or Nursing. (App. at 022, 026, 031; SR at 398, 407, 411). Additionally, all of the Plaintiffs' medical providers are board certified in their respective specialty or sub-specialties, as applicable. (*Id.*). Both Plaintiff medical facilities are licensed by the South Dakota Department of Health. (App. at 029, 034; SR at 401, 414). All of the Plaintiffs have been providing medical care for decades. (App. at 022, 025, 031; SR at 397, 407, 411).

Defendant SHP is a taxable non-profit corporation with its principal place of business in Sioux Falls, South Dakota. (SR at 42, 317). SHP has a Certificate of Authority from the South Dakota Division of Insurance to offer health benefit plans. (SR at 313). SHP's health benefit plans are offered to individuals and groups. (SR at 317). SHP's health benefit plan contracts typically have a term of one year. (SR at 182).

All of the Plaintiffs are credentialed providers and/or facilities with SHP. (App. at 022, 026, 031–032; SR at 398, 407, 411–12). All of the Plaintiffs are participating providers and/or facilities in SHP's broad network Signature Series and Simplicity Plans.

[5] Independent meaning owned and operated in whole or in part by physicians rather than being owned and operated by vertically integrated health care systems, such as Sanford Health or Avera Health.

(*Id.*). The Signature Series Plan is a large employer plan[6] that includes medical providers and facilities that expand beyond those of Sanford Health. (App. at 065-071; SR at 210). The Simplicity Plan has the same provider and facilities network as the Signature Series Plan, but the Simplicity Plan is offered to small employers and individuals.[7]

Plaintiff Sioux Falls Specialty Hospital ("SFSH"), however, was only permitted to participate in SHP's broad Signature Series and Simplicity Plans after Plaintiff SFSH brought an action against SHP. (SR at 296–99, 337–38); *see also Sioux Falls Specialty Hosp., L.L.P. v. Sanford Health Plan* (CIV. 15-899) (Second Judicial Circuit). The court in that action declined to address whether South Dakota's AWP Law applied to SHP's health benefit plans that had closed provider and facility networks. (SR at 337–38). As a result, Plaintiff SFSH and SHP reserved the right to litigate in the future whether South Dakota's AWP Law applied to health benefit plans with closed networks, narrow networks, or other similar insurance products. (SR at 298).[8]

I. The True Plans.

The SHP True Plans are the only health benefit plans that SHP offers to large employers, small employers, and individuals. (SR at 183). SHP refers to its True Plans as having a "focused network," which consists of Sanford Health providers, Sanford Health facilities, and others necessary to meet network adequacy requirements. (App. at

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[6] Large employers are defined as employers with 51 or more employees. (SR at 182).
[7] Small employers are defined as employers that employ 50 or less employees. (App. at 072-077; SR at 182, 222, 226).
[8] No Order of Dismissal was ever entered in that action and the final Order provides that "this proceeding (Civ. 15-899) is concluded and the Clerk ma[y] take any necessary steps to close the Court's file." (SR at 337–38); *see also* SDCL § 15-6-41(a)(1)(B).

065-071; SR at 212).[9] The True Plans have no out-of-network benefits available, which results in the True Plans' insureds having to pay 100% out-of-pocket to treat with providers or at facilities that are not in the True Plans' network. (SR at 184, 214).

The Plaintiffs are willing to meet SHP's terms and conditions to participate in the large employer, small employer, and individual True Plans. (App. at 022, 026, 031–032; SR at 398, 407, 411–12). However, when the Plaintiffs have requested to join the True Plans, SHP has denied the Plaintiffs' requests. (App. at 026, 031; SR at 398, 405, 411). This has resulted in Plaintiff Ophthalmology Ltd. having to turn away True Plans' insureds who were unable or unwilling to pay 100% out-of-pocket for medical treatment. (App. at 031; SR at 411).

II. The Plus Plan.

SHP's Plus Plan is offered to large employers. (App. at 065-071; SR at 216). The Plus Plan has a two-tiered network. (*Id.*). Tier 1 consists of Sanford Health providers and facilities. (*Id.*). Tier 2 of the Plus Plan has a broad network that includes medical providers and facilities that "expand[ ] beyond the Sanford Health care system." (*Id.*).

Plus Plan insureds are given financial incentives to confine their treatment to tier 1, Sanford Health providers and facilities. (SR at 188). If a Plus Plan insured treats with a tier 2 provider or at a tier 2 facility, the insured must pay twice the deductible amount the insured would otherwise pay to treat with a tier 1, Sanford Health provider or at a tier 1, Sanford Health facility. (App. At 065-071; SR at 218). Plus Plan insureds also have to pay 20% more in coinsurance to treat with a tier 2 provider or at a tier 2 facility than

[9] Network adequacy regulations require that insureds of a health benefit plan reside within 30 miles of a primary care provider and 90 miles of a specialist. (App. at 065-071; SR at 183, 213).

they would pay if they treated with a tier 1, Sanford Health provider or at a tier 1, Sanford Health facility. (*Id.*). Finally, Plus Plan insureds must pay $20 more in copay amounts for an office visit with a tier 2 provider than they would pay for an office visit with a tier 1, Sanford Health provider. (*Id.*). All of the Plaintiffs are willing to meet SHP's terms and conditions to participate in tier 1 of the Plus Plan. (App. at 022, 026, 031–032; SR at 398, 407, 411–12).

SUMMARY JUDGMENT STANDARD

Summary Judgment is properly granted when there is no genuine issue as to any material fact and the moving party is entitled to judgment as a matter of law. *Burgi v. East Winds Court, Inc.*, 2022 S.D. 6, ¶ 15, 969 N.W.2d 919, 923. The evidence is viewed in the light most favorable to the non-moving party, and reasonable doubts are resolved in the non-moving party's favor. *Id.*

A summary judgment motion is designed to "isolate and dispose of factually unsupported claims or defenses." *Stern Oil Co., Inc. v. Brown*, 2012 S.D. 56, ¶ 16, 817 N.W.2d 395, 401 (quoting *Chem-Age Indus., Inc. v. Glover*, 2002 S.D. 122, ¶ 18, 652 N.W.2d 756, 765). Once the moving party has established its burden, the nonmoving party must "present specific facts showing that a genuine, material issue for trial exists" to prevent a grant of summary judgment. *Johnson v. Hayman & Assocs., Inc.*, 2015 S.D. 63, ¶ 11, 867 N.W.2d 698, 701 (internal citations and quotations omitted). General allegations and mere denials that do not set forth specific facts will not prevent the issuance of a judgment. *Citibank South Dakota, N.A. v. Schmidt*, 2008 S.D. 1, ¶ 8, 744 N.W.2d 829, 832.

ARGUMENT

I. The AWP Law prohibits SHP from excluding Plaintiffs from SHP's health plans.

A. The general purpose of AWP laws is to prevent the obstruction of patient choice by prohibiting insurers from excluding health care providers from insurance plans.

The United States Supreme Court has recognized that any willing provider ("AWP") statutes "impair [insurers'] ability to limit the number of providers with access to their networks…." *Ky. Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 332 (2003). The issue in *Kentucky Association of Health Plans* was whether Kentucky's AWP law was preempted by the Employee Retirement Income Security Act. *Id.* at 332–33. The purpose of the AWP law, however, was never in question, as insurers in Kentucky acknowledged the "law effectively requires all health benefit plans to include in their *provider panels* any provider willing to accept the terms and conditions offered by the plan." *Cmty. Health Partners, Inc. v. Ky.*, 14 F. Supp. 2d 991, 997 (W.D. Ky. 1998) (emphasis added). According to a federal district court judge, the law "restrict[ed] risk-bearing entities [i.e., insurers] from offering health benefit plans with restricted provider networks…." *Id.* at 999.

The United States Court of Appeals for the Eighth Circuit presided over an appeal involving Arkansas's AWP law. *Prudential Ins. Co. of Am. v. Nat'l Park Med. Ctr., Inc.*, 413 F.3d 897 (8th Cir. 2005). The court described Arkansas's AWP law as follows: "[t]ypical of AWP laws, the Arkansas PPA requires health care insurers to admit qualified health care providers into the insurer's provider networks if they are willing to meet the terms and conditions of participation." *Id.* at 902.

The Supreme Court of Idaho held that Idaho's AWP law was also designed to prohibit insurers from excluding health care providers from health plans. *Idaho*

Cardiology Assocs., P.A. v. Idaho Physicians Network, Inc., 108 P.3d 370, 374–75 (Idaho 2005) ("In our view, the Idaho Legislature's primary purpose in enacting the any willing provider statute was to preserve, to the maximum extent possible, the right of a patient to select his own treatment provider, subject only to the provider's willingness and ability to comply with the basic requirements of the managed care plan."). Other courts have also recognized that the purpose of AWP laws is to prohibit insurers from excluding health care providers from the insurers' plans. *See, e.g.*, *High Mountain Corp. v. MVP Health Care, Inc.*, 416 F. Supp. 3d 347, 350 (D. Vt. 2019) ("These statutes [i.e., AWP laws] limit the ability of health maintenance organizations and insurance companies to restrict participation and reimbursement to select providers."); *Quality Infusion Care Inc., v. Humana Health Plan of Tex. Inc.*, 290 Fed. Appx. 671, 678 (5th Cir. 2008) (unpublished) ("The purpose of any willing provider laws is to allow freedom of choice to policyholders and allow health care providers access to HMOs and PPOs."); *Am. Drug Stores, Inc. v. Harvard Pilgrim Health Care, Inc.*, 973 F. Supp. 60, 62 (D. Mass. 1997) ("The Act, like other any willing provider statutes, serves the dual purposes of protecting providers and ensuring patients of greater access to services.").

In this appeal, SHP claims that South Dakota's AWP Law is different than the AWP laws of other states. Specifically, SHP claims it can accept health care providers into what SHP defines as its overall panel of providers, allow them to participate in one of SHP's plans, and then exclude the providers from participating in what SHP characterizes as its "sub-panel of providers" for its other plans. (Appellant's Br., p. 7).

In other words, SHP asserts that South Dakota's AWP Law does not prohibit SHP from excluding health care providers, but that it actually authorizes SHP to do so.[10]

As set forth below, SHP's argument is contrary to the text and purpose of South Dakota's AWP Law. Further, SHP's argument was rejected by a committee of the South Dakota Legislature when SHP attempted to have the AWP Law amended in 2016 to comport with its attempted construction of the AWP Law.

B. Consistent with its purpose of preventing obstruction of patient choice, the text of the AWP Law confirms it is plan specific and that SHP cannot circumvent the law by including Plaintiffs in some plans but excluding them from others despite the Plaintiffs meeting the AWP Law's participation criteria.

Statutory interpretation is a question of law. *Payne v. State Farm Fire & Cas. Co.*, 2022 S.D. 3, ¶ 11, 969 N.W.2d 723, 726; *In Re an Appeal by an Implicated Individual*, 2021 S.D. 61, ¶ 16, 966 N.W.2d 578, 583 (*Sanford I*); *Sanford v. Sanford*, 2005 S.D. 34, ¶ 12, 694 N.W.2d 283, 287. When a trial court resolves a question of statutory interpretation in a litigant's favor, summary judgment is appropriate. *Ries v. JM Custom Homes, LLC*, 2022 S.D. 52, ¶ 14, 980 N.W.2d 217, 222 (quoting *Sioux Valley Hosp. Ass'n v. State*, 519 N.W.2d 334, 335 (S.D. 1994)).

[10] SHP has narrowed its arguments considerably over the course of this litigation. Initially, SHP denied it was a health insurer and claimed it was therefore not subject to the AWP Law. (SR at 372–73). SHP also claimed that despite the Plaintiffs being credentialed with SHP, the Plaintiffs were not qualified to participate in the plans at issue. (SR at 372). Finally, SHP claimed the Plaintiffs lacked standing to bring this action. (App. 006–012; SR at 1262–68). By the time of the summary judgment hearing, however, SHP was conceding it was a health insurer subject to the AWP Law and that the Plaintiffs were qualified to participate. The circuit court rejected SHP's standing argument and SHP has not appealed that ruling. (*Id.*). Thus, the only issues that remain are whether the text of the AWP Law allows SHP to exclude the Plaintiffs and whether a genuine issue of material fact exists with respect to the Plaintiffs' willingness to participate.

The AWP Law provides:

> No health insurer, including the South Dakota Medicaid program, may obstruct patient choice by excluding a health care provider licensed under the laws of this state from participating on the health insurer's *panel of providers* if the provider is located within the geographic coverage area of the *health benefit plan* and is willing and fully qualified to meet the *terms and conditions of participation* as established by the health insurer.

SDCL § 58-17J-2 (emphasis added).

The AWP Law prohibits health insurers from *obstructing patient choice* by excluding a health care provider from the health insurer's "*panel of providers* if the provider is located within the geographic coverage area of *the health benefit plan*...." SDCL § 58-17J-2 (emphasis added). "Health benefit plan" is defined for purposes of the AWP Law to include "*any* health benefit plan that affects the rights of a South Dakota insured[.]" SDCL § 58-17J-1 (App. At 083) (emphasis added). Thus, the AWP Law contemplates that there is a health insurer offering a health benefit plan in a specific geographic coverage area and that the health insurer has a panel of providers participating in that plan. The AWP Law further contemplates that the insurer has established "terms and conditions of participation" for the panel of providers of the plan it is offering.

The circuit court correctly observed that the use of the term "plan" in the singular demonstrates that the AWP Law contemplates a panel of providers for each plan. (App. at 015; SR at 1271). If, as suggested by SHP, the AWP Law contemplates a single panel of providers that is specific to the insurer as opposed to the individual plan, the AWP Law would refer to "plans" in the plural because there would only be one panel of providers specific to the insurer. The AWP Law, however, refers to "*the* plan" as opposed to "the plans" or "any plan." And the AWP Law refers to "*the* geographic

coverage area" and "*the* terms and conditions," as opposed to "[*any*] geographic coverage area of [*any*] health benefit plan."

Indeed, the AWP Law's text indicates that its drafter understood that health insurers offer multiple plans that have different geographic coverage areas and different terms and conditions. As a result, those individual plans each have an individual "panel of providers." Because "panel of providers," as set forth in the AWP Law, is plan specific, an insurer cannot, as SHP suggests, circumvent the law by including a provider in one plan and subsequently excluding that provider from all other plans for which the provider meets the AWP Law's criteria.

Of course, the drafters of the AWP Law did not invent the term "panel of providers." That term had been used by the South Dakota Legislature in statutory enactments that pre-date the passage of the AWP Law, and a review of those statutes confirms that "panel of providers" is plan specific. For example, the South Dakota Legislature defines a "closed panel plan" as: "*a plan* that provides health benefits to covered persons primarily in the form of services through a *panel of providers* that have contracted with or are employed by the *plan*…." SDCL § 58-18A-53(3) (emphasis added). In addition, SDCL § 58-18A-64 provides in relevant part:

> Under the terms of a closed *panel plan*, no benefits are payable if the covered person does not use the services of a closed *panel provider*. No COB occurs if a covered person is enrolled in two or more closed *panel plans* and obtains services from a provider in one of the closed *panel plans* because the other closed *panel plan* (the one whose providers were not used) has no liability….

(Emphasis added).

Thus, the Legislature has used "panel of providers" in a plan-specific, as opposed to insurer-specific, manner. The Legislature did so prior to the enactment of the AWP

Law and used "panel of providers" in connection with "closed plan." Because the purpose of AWP laws is to impair an insurer's ability to limit the number of providers in the insurer's plan networks (i.e., panel of providers), thereby promoting patient choice, it is not surprising that the term "panel of providers" appears in the definition of "closed plan" and in the subsequently enacted AWP Law.

In addition to the South Dakota Legislature, courts have used "panel of providers" or "provider panels" in a plan-specific manner. *See Cmty. Health Partners*, 14 F. Supp. 2d at 997 (Kentucky AWP law "effectively requires all *health benefit plans* to include in *their provider panels* any provider willing to accept the terms and conditions offered by *the plan*") (emphasis added); *Prudential Ins. Co. of Am., et al. v. Nat'l Park Med. Ctr., Inc.*, 964 F. Supp. 1285, 1298 (E.D. Ark. 1997) (overruled on other grounds) (noting the Arkansas AWP law intended to bar "exclusive provider agreements and *closed-panel* PPOs or HMO *networks*") (emphasis added). Accordingly, by its plain language, the AWP Law is plan specific and precludes SHP from excluding Plaintiffs from its plans, consistent with its purpose of preventing obstruction of patient choice.

C. SHP's attempt to avoid complying with the AWP Law by claiming it is insurer specific is contrary to the purpose and text of the AWP Law, and such construction was rejected by the South Dakota Legislature.

1. SHP's insurer-specific construction of the AWP Law defeats the AWP Law's purpose and ignores the AWP Law's full text.

Rather than conform its conduct to the law, SHP has attempted to conform the law to its conduct. SHP attempts to do so by defining "panel of providers" as being specific to the insurer, as opposed to being specific to the plan. SHP claims that it has one panel of providers as an insurer, and other "subset" panels of providers for each plan. (Appellant's Br., p. 26) (referring to the SHP True Plan's panel of providers as a "subset

of SHP's entire panel of providers").[11] In this regard, SHP is trying to manufacture a scenario where it can claim to this Court that it complies with the AWP Law by including independent providers on what SHP defines as its "panel of providers," but can exclude those same independent providers from SHP's plans because they are not part of what SHP characterizes as the plans' "subset" panels of providers. And when medical providers who meet the AWP Law's criteria request to participate, SHP can say, "congratulations, you are on our panel of providers, but no, you cannot participate in our plan."

SHP's argument that "panel of providers" is insurer specific would undermine the purpose of the AWP Law. Specifically, insurers would be able to exclude licensed health care providers from participating in an insurer's health benefit plan. Insurers could do so notwithstanding the fact that the health care provider meets the AWP Law's criteria. In other words, SHP's interpretation would result in qualified and willing providers who are nevertheless unable to participate (i.e., an any willing, but not able, provider law). As for the insureds in those plans, they would be unable to treat with the excluded providers, which would result in precisely what the AWP Law is designed to avoid—obstruction of patient choice in their health care providers.

SHP's interpretation also essentially deletes the second half of the AWP Law, which explains why SHP cites the AWP Law and neglects to cite the language that follows "panel of providers." (Appellant's Br., p. 15, "excluding a health care provider…from participating on the health insurer's panel of providers…."). But the

[11] Perhaps not so coincidentally, it is the medical providers employed by and facilities owned by SHP's parent, Sanford Health, that are included on the "subset" panels and who are therefore able to participate in SHP's plans.

phrase "health insurer's panel of providers" begs the question: panel of providers for what? That question is answered in the second half of the AWP Law: "the health benefit plan." Indeed, "health insurer," by its very definition, is "an entity offering a health benefit plan…." SDCL § 58-17J-1 (App. at 083). And the ability of a health care provider to participate on the health insurer's panel of providers for its health benefit plan depends upon whether the health care provider is located within the geographic coverage area of *the plan* and is willing and fully qualified to meet its terms and conditions.

Finally, SHP's current position is also contrary to the position SHP took in a 2015 Petition for Declaratory Ruling before the South Dakota Division of Insurance. (SR at 314–24). The Petition was verified by SHP's then President, Ruth Krystopolski. (*Id.*). The opening paragraph of the Petition provides

> 1.0 In 2014, South Dakota voters approved Initiated Measure 17 ("IM-17"), enacting an "any willing provider law." By *its terms*, IM-17 forces health benefit *plans* to allow any licensed health care provider to participate in the *plan's* "panel of providers" if, among other things, the provider is "fully qualified to meet the terms and conditions of participation as established by the health insurer."

(SR at 314) (quotations in original) (emphasis added).

Despite its efforts, SHP cannot achieve an end run around the AWP law by now changing course and attempting to re-define or re-characterize "panel of providers." Construing "panel of providers" as specific to each plan is consistent with the AWP Law's purpose of ensuring patient choice in their medical providers by prohibiting insurers from excluding willing and qualified providers from the insurers' plans. *Idaho Cardiology Assocs.*, 108 P.3d at 374–75 (rejecting a trial court's narrow interpretation of an undefined term in an AWP law because such an interpretation would contravene the

law's purpose of promoting patient choice). Accordingly, the circuit court's grant of summary judgment should be affirmed.

2. SHP is asking this Court to judicially amend the AWP Law in a manner that was previously rejected by the Legislature.

It is not the province of the judiciary to re-write or amend legislation. *MGA Ins. Co., Inc. v. Goodsell*, 2005 S.D. 118, ¶ 29, 707 N.W.2d 483, 488. Nor is it the role of courts to question the wisdom of legislation or create exceptions to it. *State v. Burdick*, 2006 S.D. 23, ¶ 18, 712 N.W.2d 5, 10. SHP claims that defining "panel of providers" in a manner that allows it to exclude medical providers increases consumer choice in health insurance plans. (Appellant's Br., p. 7). The intent of the AWP Law, however, is to preserve patients' choice in their *health care providers*—not health insurance plans. If SHP wants to preserve its ability to offer insurance plans consisting of only Sanford Health providers, the proper audience for its arguments is the electorate or the Legislature. SHP already has attempted to pursue its aims with both, however, and failed on both occasions.

Specifically, after SHP and other opponents of the AWP Law were defeated at the ballot box, South Dakota House Bill 1067 was introduced and considered by the House Commerce and Energy Committee.[12] House Bill 1067 was titled: "An Act to promote quality, competition, and freedom of choice in the *health insurance marketplace*." (Emphasis added). The bill proposed to amend the AWP Law's definitions (SDCL § 58-17J-1) to define "panel of providers" as "a list of *all* health care providers under contract with a health insurer for inclusion in *one* or more of the health insurer's health benefit

[12] House Bill 1067 and the history related to it can be found on the South Dakota Legislature's website available at https://sdlegislature.gov/Session/Bill/7225 (last visited May 16, 2023).

plans." (Emphasis added). Thus, House Bill 1067 would have defined "panel of providers" precisely the way SHP is urging it be defined in this case—as specific to the insurer and not the individual plan.

House Bill 1067 also proposed to amend the AWP Law and add the following underlined language:

> No health insurer, including the South Dakota Medicaid program, may obstruct patient choice by excluding a health care provider licensed under the laws of this state from participating on the health insurer's panel of providers if the provider is located within the geographic coverage area of the health benefit plan and is willing and fully qualified to meet the terms and conditions of participation as established by the health insurer. <u>All health insurers shall offer for sale at least *one* health benefit plan approved by the division that contains *all* of the health care providers which are in its *panel of providers*. However, nothing in this chapter limits a consumer's ability to purchase, or a health insurer's ability to offer for sale, health benefit plans that contain *less than all* of the health care providers which are in a health insurer's *panel of providers*.</u>

(HB 1067) (emphasis added). The proposed language amending the AWP Law would have given insurers the right to do what SHP claims it has the right to do in this case—include a provider in one plan and exclude the provider from all others, regardless of whether the provider meets the AWP Law's criteria.

Cindy Morrison, a Sanford Health administrator, testified in favor of the bill.[13] Ultimately, House Bill 1067 was killed in committee. The bill received only three of the possible thirteen committee member votes.

Having failed to prevent the AWP Law's passage or legislatively amend it, SHP now is attempting to persuade this Court that "panel of providers" in the current version of the AWP Law means what it would have meant had the AWP Law been amended by

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[13] The testimony concerning HB 1067 is available online at the South Dakota Legislature's website. Ms. Morrison's testimony begins at 1:32:10, available at https://sdpb.sd.gov/sdpbpodcast/2016/hco19.mp3#t=4560 (last visited May 16, 2023).

House Bill 1067. Specifically, SHP argues that "panel of providers" is insurer specific as opposed to plan specific, and if an insurer admits a willing and qualified provider on its "panel of providers" and allows it to participate in one plan, the insurer can exclude the provider from its "subset" panels of providers for all other plans.

In that respect, SHP is requesting that this Court undo what the voters did and do what a committee of the South Dakota Legislature refused to do. But courts do not legislate. Therefore, if SHP wants to pursue efforts to transform the AWP Law into a "freedom to treat only with Sanford Health providers" law, it should return to the electorate or the Legislature rather than attempting to achieve its legislative aims through the courts.[14]

D. The AWP Law does not impliedly repeal other provisions of the insurance code.

SHP claims that interpreting "panel of providers" in the AWP Law as plan specific would judicially repeal the statutes related to closed plans and render closed plans "illegal." (Appellant's Br., p. 22). Aside from that broad and histrionic pronouncement, however, SHP does not set forth the text of the closed plan statutes it claims would be rendered "illegal" or explain why the closed plan statutes cannot be reconciled with the AWP Law. Yet this Court's precedent related to repeal by

[14] After this appeal was filed, the North Dakota Legislature passed House Bill No. 1416, which is nearly identical to South Dakota's AWP Law. North Dakota's law, however, differs in that it targets only health systems that offer both health care services and health benefit plans (i.e., Sanford Health). North Dakota's Governor vetoed the bill, but the North Dakota Legislature voted to override the Governor's veto by a vote of 90-0 in the House, and 36-11 in the Senate. North Dakota House Bill No. 1416 is available at https://www.ndlegis.gov/assembly/68-2023/regular/documents/23-0983-04000.pdf (lasted visited May 16, 2023).

implication requires exactly that—an examination of the statutes and a determination if there is any reasonable construction by which the statutes can be reconciled.

If two statutes appear to conflict, it is the duty of courts to make them harmonious and workable. *Faircloth v. Raven Indus., Inc.*, 2000 S.D. 158, ¶ 7, 620 N.W.2d 198, 201. Courts must "give effect to both enactments if their provisions can be reconciled." *Friessen Const. Co., Inc. v. Erickson*, 238 N.W.2d 278, 280 (S.D. 1976) (citation omitted). "Repeal by implication will be indulged only where there is a manifest and total repugnancy." *Karlen v. Janklow*, 339 N.W.2d 322, 323 (S.D. 1983). If two statutes are irreconcilable, however, the latter statute prevails. *Matter of Sales Tax Refund Applications of Black Hills Power & Light Co.*, 298 N.W.2d 799, 803 (S.D. 1980).

"Closed plan" or "closed panel plan" is defined four times in Title 58 of the South Dakota Code. *See* SDCL § 58-17F-1(1); SDCL § 58-17G-1(1); SDCL § 58-17I-1(8); SDCL § 58-18A-53(3). The network adequacy standards, quality assessments and improvements, and grievance procedure chapters of Title 58 define "closed plan" in identical fashion:

> "Closed plan," a managed care plan or health carrier that requires covered persons to use participating providers under the terms of the managed care plan or health carrier and *does not provide any benefits for out-of-network services* except for emergency services.

SDCL § 58-17F-1(1); SDCL § 58-17G-1(1); SDCL § 58-17I-1(8) (emphasis added). The coordination of benefits of health plans chapter in Title 58 defines "Closed panel plan" as:

> "Closed panel plan," a plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan and that *excludes benefits for services provided by other providers*, except in cases of emergency or referral by a panel member.

SDCL § 58-18A-53(3) (emphasis added). An open plan, on the other hand, is defined as:

> "Open plan," a managed care plan or health carrier other than a closed plan that provides incentives, including financial incentives, for covered persons to use participating providers under the terms of the managed care plan or health carrier.

SDCL § 58-17G-1(16); SDCL § 58-17F-1(18); SDCL § 58-17I-1(29).

The AWP Law can be reconciled with the statutes related to closed plans because the AWP Law does not require a health insurer to *pay benefits* for services rendered by a provider that is *not participating* on the panel. Instead, the AWP Law prohibits insurers from *excluding providers* that meet the AWP Law's criteria *from participating* on the plan's panel.

The closed plans, by their statutory definition, remain closed, because unlike open plans, no benefits are available for non-participating providers. SDCL § 58-18A-64 ("Under the terms of a closed panel plan, no benefits are payable if the covered person does not use the services of a closed panel provider."). Nor are closed plans, as SHP suggests, rendered "illegal" by enforcing the AWP Law.

The AWP Law simply impairs the insurer's ability to limit the number of providers on the closed plan's panel or, in this case, impairs SHP's ability to limit its panel solely to the health care providers of its parent company, Sanford Health. As set forth in section I(A) above, this is precisely what AWP laws are designed to do.

Insurers may still create closed plans. Those plans will remain closed to providers outside of the plan's geographic coverage area. Those plans will also remain closed to providers unwilling to meet the plan's terms and conditions. *Good Shepherd Med. Ctr., Inc. v. State*, 306 S.W.3d 825, 836 (Tex. App. 2010) ("[E]ven in an 'any willing provider'

regime, there may be only one provider willing to agree to the plan's specified terms and conditions."). To the extent an insured treats with a provider who is not participating on the closed plan's panel of providers, that provider will be deemed out-of-network and no benefits will be available to the insured except for emergency services. Thus, the plan will remain a "closed plan" as defined by South Dakota law. SDCL § 58-18A-53.

SHP claims that while the circuit court may have been correct that the AWP Law does not foreclose an insurer from creating a closed plan, the circuit court failed to acknowledge that the AWP Law cannot be harmonized with SDCL § 58-17F-11(7). (Appellant's Br., p. 23). That statute permits health carriers and participating providers to terminate their contracts with one another without cause upon sixty days written notice. SDCL § 58-17F-11(7).

The provider's right to terminate its contract with a health carrier is not implicated by the AWP Law. With respect to the health carrier's ability to terminate a provider without cause, the health carrier still can do so. What the health carrier cannot do, however, is terminate the provider for the purpose of excluding the provider or terminate the provider because the provider is not an employee of the health carrier or one of its affiliates. In short, like the statutes related to closed plans, SDCL § 58-17F-11(7) can be reconciled with the AWP Law.

There are only two statutes that otherwise appear to conflict with the AWP Law's prohibition on insurers excluding willing and qualified providers. However, even these statutes can be reconciled with the AWP Law based on their express limitations in scope. Specifically, South Dakota Codified Law § 58-17F-11(3) provides:

> *The provisions of this chapter* do not require the health carrier, its intermediaries or the provider networks with which they contract, to

> employ specific providers or types of providers that may meet their selection criteria, or to contract with or retain more providers or types of providers than are necessary to maintain an adequate network.

SDCL § 58-17F-11(3) (emphasis added). In addition, South Dakota Codified Law § 58-41-2 provides in relevant part:

> *Nothing in this chapter* prohibits a health maintenance organization holding a certificate of authority in this state from issuing contracts to enrollees on a preferred provider, exclusive provider, or closed panel basis.

SDCL § 58-41-2 (emphasis added).

But both statutes can be reconciled with the AWP Law because the statutes are prefaced with "[t]he provisions of this chapter do not require" and "[n]othing in this chapter prohibits…." SDCL § 58-17F-11(3); SDCL § 58-41-2. The Legislature certainly could have prefaced SDCL § 58-17F-11(3) or SDCL § 58-41-2 with stronger language that would have reached beyond their individual chapters, such as "nothing in this *title*" or "*notwithstanding* any other *provision of law*." Instead, however, the Legislature confined these statutes to their individual chapters, despite knowing how to make their reach broader than the chapter in which they appear. *See* SDCL § 58-1-3.1 ("Notwithstanding any other provision of law…."). And while nothing in Chapters 58-17F or 58-41 prohibits SHP's conduct, the AWP Law in Chapter 58-17J plainly does.

In summary, the statutes cited by SHP, when construed with the AWP Law, do not lead to a result that is manifestly and totally repugnant. *In re Approval of Request for Amendment to Frawley Planned Unit Dev.*, 2002 S.D. 2, ¶ 16, 638 N.W.2d 552, 557 (citation and emphasis omitted) ("Repeal by implication will be indulged only where there is a manifest and total repugnancy. If, by any reasonable construction, both acts can

be reconciled, they should be."). Instead, these statutes can be reconciled with the AWP Law. [15]

To the extent the statutes above and the AWP Law cannot be reconciled, however, the AWP Law would prevail as it became effective later in time. *Simpson v. Tobin*, 367 N.W.2d 757, 763 (S.D. 1985); *Matter of Sales Tax Refund,* 298 N.W.2d at 803. Specifically, South Dakota Codified Law § 58-17F-11 became effective in 2011 and SDCL § 58-41-2 in 2013. The statutes SHP relies upon that are in Chapter 58-17F were enacted in 2011 and the statutes located in Chapter 58-18A were enacted in 2006. The AWP Law became effective November 13, 2014. SDCL 58-17J-2. Thus, even if there were an irreconcilable conflict, SHP cannot escape application of the AWP Law.

II. SHP cannot rely upon its "Highly Confidential" designation of the terms and conditions of its contract with Sanford Health to create a genuine issue of material fact as to whether Plaintiffs are willing to accept those same terms and conditions.

Prior to SHP responding to the Plaintiffs' discovery requests, the parties stipulated to the entry of a Protective Order. (SR at 79–88). The Protective Order permitted the parties to designate discovery material as "Highly Confidential." (SR at 81). If an attorney designated discovery materials as "Highly Confidential," those discovery materials could only be disclosed to the attorneys, attorneys' support staff, and any experts retained by the attorneys. (*Id.*). The non-disclosing parties were not permitted to view materials designated as "Highly Confidential." (*Id.*).

When SHP disclosed the contract it had with Sanford Health, which contained all of the terms and conditions for participating in SHP's plans, SHP designated that contract

[15] The AWP Law also can be reconciled with the administrative rules cited by SHP, but it is not necessary to do so because it is well settled that statutes prevail over rules in the event of a conflict. *Upell v. Dewey Cty. Comm'n*, 2016 S.D. 42, ¶ 14, 880 N.W.2d 69, 74.

as "Highly Confidential." (SR at 233–292). As the litigation progressed, it became apparent that SHP would attempt to create a genuine issue on the Plaintiffs' willingness to accept the terms and conditions of the plans. SHP attempted to do so by using the "Highly Confidential" designation to prevent the Plaintiffs from reviewing those terms and conditions. For example, when SHP deposed the Chief Executive Officer of Orthopedic Institute, Lynda Barrie, the following exchange took place:

> Q: Do you know what the reimbursement rates are for the Sanford True Plan?
>
> A: No.
>
> Q: I assume you know – well, do you know what the reimbursement rates are for the Sanford Signature Plan?
>
> A: I would have to look that up. I don't know off the top of my head.
>
> Q: You're in network for a Signature Plan, so you have records on that; right?
>
> A: Yes, yes.
>
> MR. DAMGAARD: I should clarify, Marty, too, I think the reimbursement rates for the True Plan are attorneys' eyes only right now, but if you wanted to take a recess and look at them and ask her whether she would be good with them, we'll certainly do that.
>
> MR. CHESTER: Thanks. I'll ask the questions.

(SR at 994).

Despite the inability to review terms and conditions of SHP's contract with Sanford Health, the Plaintiffs set forth in affidavits that they were willing to accept those terms and conditions. (App. at 022, 026, 031; SR at 398, 407, 411). The Plaintiffs were able to do so for several reasons. First, the Plaintiffs did not have to be concerned about any of the terms of credentialing as the Plaintiffs were already credentialed with SHP

through their participation in SHP's broad network Signature Series and Simplicity Plans. (App. at 022, 026, 031–032; SR at 398, 407, 411–412); (Appellant's Br., n. 7). Second, with respect to the reimbursement rates, the Plaintiffs could assume that whatever SHP was reimbursing Sanford Health, such rates would be greater than what SHP would reimburse the Plaintiffs for treating patients insured by SHP's closed plans—which was nothing since the Plaintiffs were being precluded from participating. (App. at 065-071; SR at 214–15). Third, the Plaintiffs could assume that the reimbursement rates of a private commercial insurer, such as SHP, would be greater than Medicaid and most likely greater than Medicare. Finally, the Plaintiffs could assume it was highly likely that the reimbursement rates were significant given that SHP was making such payments directly to its own parent company, Sanford Health.

Unlike the Plaintiffs, Plaintiffs' counsel did have the opportunity to review the terms of the contract between SHP and Sanford Health. (SR at 233–292). Plaintiffs' counsel also had the opportunity to compare the reimbursement rates SHP paid to Sanford Health on SHP's allegedly "more affordable" True and Plus plans and the reimbursement rates SHP paid to Plaintiff SFSH on the allegedly "more expensive" Signature Series and Simplicity plans (i.e., the broad plans).[16]

For inpatient claims, SHP reimburses Plaintiff SFSH a base rate of **[REDACTED]** for the "more expensive" Signature Series and Simplicity large and small employer plans. (SR 301). That base rate is **[REDACTED]** SHP reimburses Sanford

[16] SHP claims that its True and Plus plans are more affordable because SHP is able to "negotiate" lower reimbursement rates by directing care to a "smaller number of physicians," which notably are limited to those of its parent, Sanford Health. (Appellant's Br., p. 9).

Health for the "more affordable" large and small employer True Plans and the large employer Plus Plan. (SR at 258).

For outpatient claims, SHP reimburses Plaintiff SFSH a base rate of **[REDACTED]** for the Signature Series large employer plan and Simplicity small employer plan. (SR at 302). That base rate is **[REDACTED]** SHP reimburses Sanford Health for the "more affordable" large and small employer True Plans and the large employer Plus Plan. (SR at 261).

For professional services, SHP reimburses Plaintiff SFSH a base rate of **[REDACTED]** for the Signature Series large employer plan and Simplicity small employer plan. (SR at 304). SHP reimburses **[REDACTED]** for the "more affordable" large and small employer True Plans and the large employer Plus Plan. (SR at 168).

For clinical laboratories, SHP reimburses Plaintiff SFSH in an amount **[REDACTED]** what Medicare reimburses for clinical laboratories. (SR at 305). That amount, however, is **[REDACTED]** SHP reimburses Sanford Health for clinical laboratories under the "more affordable" large and small employer True Plans and the large employer Plus Plan.

After reviewing the reimbursement rates, Plaintiffs' counsel represented to the circuit court that on behalf of the Plaintiffs, counsel was expressing their willingness to

agree to the terms of the True and Plus plans. (SR at 1159).[17] In support of that assertion, Plaintiffs' counsel cited SDCL § 16-18-11, which provides that an attorney can bind his client to an agreement.

A protective order cannot be used as both a shield and a sword. *State ex rel. State Farm Mut. Auto. Ins. Co. v. Bedell*, 719 S.E.2d 722, 740 (W. Va. 2011) (quoting *Fritsch v. City of Chula Vista*, 187 F.R.D. 614, 626 (S.D. Cal. 1999)); *see also Sony Computer Entm't Am., Inc. v. NASA Electronics*, 249 F.R.D. 378, 383 (S.D. Fla. 2008). That is precisely what SHP is attempting to do here—withhold the terms and conditions of the plans from the Plaintiffs and defend on the grounds that the Plaintiffs cannot be certain they would accept the terms and conditions because they have not reviewed the plans.

The Plaintiffs suspected, however, that whatever the reimbursement rates were, they would be favorable on account of SHP reimbursing its parent, Sanford Health. As a result, the Plaintiffs indicated their willingness to accept the terms and conditions of the True and Plus plans despite not having reviewed the plans. After Plaintiffs' counsel reviewed the terms and conditions and confirmed the Plaintiffs' suspicions, he accepted those terms and conditions on the Plaintiffs' behalf. No trial is necessary to determine whether the Plaintiffs will accept higher reimbursement rates under the plans at issue than they currently receive from SHP on its other plans. Accordingly, the circuit court's decision granting summary judgment to the Plaintiffs should be affirmed.

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[17] SHP claims that Plaintiffs' counsel expressed the Plaintiffs' willingness to agree to the True and Plus plans in an affidavit. (Appellant's Br., p. 12, p. 13, p. 30). SHP most likely believes that because the circuit court's memorandum decision indicates that Plaintiffs' counsel submitted such an affidavit. (App. at 012; SR at 1268). The statement, however, was made in a brief, and the basis for the Plaintiffs' willingness was a citation to an affidavit by counsel, which included an exhibit that set forth the plans' terms and conditions, including the reimbursement rates that SHP was paying Sanford Health under the True and Plus Plans.

III. The circuit court correctly declined SHP's invitation to scrutinize whether the AWP Law was sound public policy.

During the summary judgment proceeding, SHP put forth essentially the same arguments that it and amicus curiae ("Avera Health Plans" or "AHP") have put forth in this appeal. Those arguments are, in large part, based upon what SHP and AHP believe is sound public policy. They claim that interpreting the AWP Law according to its plain language would deprive individuals of choice with respect to health plans and therefore increase the cost of health insurance.[18]

Arguments about wisdom and fairness may implicate public policy, but not appellate error. *Trask v. Meade Cty. Comm'n*, 2020 S.D. 25, ¶ 34, 943 N.W.2d 493, 501. Indeed, this Court has long held that questions about the wisdom, justice, policy, or the expediency of a statute are for the Legislature. *Travaillie v. City of Sioux Falls et al.*, 240 N.W. 336, 339 (S.D. 1932) ("Courts are not instituted for the purpose of passing upon the wisdom of legislation.").

The circuit court stated that SHP's policy arguments were "somewhat disingenuous." (App. at 011; SR at 1267). Aside from that comment, the court disregarded SHP's policy arguments and simply applied the plain language of the AWP Law to conclude "panel of providers" was plan specific. (App at 012–016; SR at 1268–63).

[18] SHP points to the fact that it includes the Plaintiffs in its broad Signature Series and Simplicity plans for support that it gives consumers a choice in their health plans. (Appellant's Br., p. 3). As set forth above, however, the AWP Law's intent is to provide patients with the freedom to choose healthcare providers, not health insurance plans. And Plaintiff SFSH had to bring an action in 2015 against SHP before Plaintiff SFSH was allowed to participate in SHP's Signature Series and Simplicity plans.

Although cases involving AWP laws often involve parties who invite the courts to veer from their proverbial lanes, this case presents a less appealing invitation. That is because most AWP law cases involve conventional insurers. The courts presiding over those cases have no reason to doubt that the conventional insurer created a closed network for the purpose of offering lower premiums or increasing its profits. In those situations, the health insurer has no economic motivations to discriminate against a class of providers. Instead, a conventional health insurer may simply desire to contract with whoever is willing to accept the lowest reimbursement rates and still meet the conventional insurer's quality of care standards. But in this case, SHP and AHP are health insurers that are also subsidiaries of *health care systems*.[19] As such, SHP, AHP, and their health system parents may have every incentive to not only obstruct patient choice, but ultimately to eliminate it.

Specifically, the taxable non-profit health insurer is motivated to move the highest percentage of premium dollars possible to its non-taxable, non-profit health system parent. As the number of insureds in the health insurer's closed plans increase, the

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[19] Despite SHP and AHP's claims that they "negotiate" lower reimbursement rates in exchange for closed panels, it is always the medical providers from their own health systems that comprise the closed panels. And absent a clear mandate from this Court, SHP's conduct is unlikely to change. Indeed, SHP has indicated that it will not comply with the circuit court's Order by claiming, for the first time on appeal, that the Order does not extend to the Plus Plan and that the Plaintiffs are not entitled to the same reimbursement rates (i.e. "terms and conditions") as Sanford Health's providers receive from the closed plan. (Appellant's Br., p. 17, n. 3; pp. 30-31). Contrary to SHP's eleventh-hour arguments, the circuit court's decision set forth that the Plaintiffs were seeking to participate in tier 1 of the Plus Plan. (App. at 004; SR at 1260) ("Plaintiffs have requested to join the TRUE Plan network and Tier 1 of the PLUS Plan network…"). The circuit court also stated that "[i]f this Court were to grant Plaintiffs summary judgment, Plaintiffs would be allowed to participate in *all* of SHP's plans, which would likely cure their alleged injury." (*Id.* at 009; SR at 1265) (emphasis added). Finally, with respect to the way SHP had set up the plans at issue, the Court held that "such a scheme is contrary to the plain language of the statute." (*Id.* at 015; SR at 1271).

amount of premiums collected by the health insurer increases. This, in turn, increases the amount of revenue received by the parent health system while the number of patients available to its independent medical provider competitors continues to decrease. The obstruction of patient choice becomes more and more prevalent until the health insurer obtains a large enough market share to eliminate the independent medical provider competitors altogether. In the end, the only choice patients will have is to treat with health systems that are also in the health insurance industry. The only choice the independent medical providers will have is to work for one of those health systems or face financial ruin.

As set forth in AHP's Amicus Brief, AHP and SHP now have the second and third largest market shares of South Dakota's health insurance industry. (Amicus Br., p. 2). However, the insurer with the largest market share in South Dakota, Wellmark of South Dakota, Inc., somehow managed to accumulate a market share greater than AHP and SHP combined. And it did so without excluding any qualified and willing providers from its plans, which is extraordinary, if, as suggested by SHP and AHP, a health insurer needs to exclude qualified and willing providers to offer "affordable" health insurance.[20]

Efforts to control both the supply and demand side of an industry are not uncommon. With respect to the health care industry, this Court has presided over cases where parties were acting in an anti-competitive manner. *South Dakota Physician's*

[20] The other inference would be that a significant number of citizens in a state with a median household income of $64,000 have chosen to purchase and maintain Wellmark's "unaffordable" plans. In any event, neither Wellmark nor the South Dakota Medicaid program are parties to this action, nor have they expressed any interest in this action, despite being subject to the AWP Law. Although notably, neither Wellmark nor the South Dakota Medicaid program operate in both the health insurance and health care industry, and, as a result, neither would have any reason to exclude qualified and willing medical providers, which may explain their lack of interest.

Health Group v. State, 447 N.W.2d 511, 515 (S.D. 1989). This Court upheld the State's exercise of its police power to single out health maintenance organizations and preferred provider organizations as those "groups, by their nature, have a great potential for funneling patients away from [other health care providers]." *Id.* at 515. In addition, discrimination against a class of health care providers "affect[ed] patients' choices and contracting ability." *Id.*

In this case, the policy considerations were made by the voters in 2014. They voted overwhelmingly to allow patients to have the freedom to choose their medical providers, regardless of whether those providers are affiliated with the patients' health insurer or if the providers are independent. In other words, the voters favored choice amongst patients and competition amongst health care providers.

The competition favored by the voters, however, was not competition with respect to the cost of care. Indeed, if allowed into SHP's closed plans, the Plaintiffs will receive the same reimbursement rates SHP pays Sanford Health providers. The competition will therefore be limited to the *quality of care* provided.

This Court, like the circuit court, does not have to entertain policy arguments. Instead, this Court can confine its analysis to the plain language of the AWP Law and simply declare its meaning.

CONCLUSION

For all the reasons above, the circuit court's decision, which granted summary judgment for the Plaintiffs and declared that SHP cannot exclude medical providers that meet the AWP Law's criteria from participating in SHP's health plans, should be affirmed.

Respectfully submitted this 19th day of May, 2023.

WOODS, FULLER, SHULTZ & SMITH P.C.

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CERTIFICATE OF COMPLIANCE

In accordance with SDCL § 15-26A-66(b)(4), we certify that this brief complies with the requirements set forth in the South Dakota Codified Laws. This brief was prepared using Microsoft Word 365, Times New Roman (12 point) and contains 9,787 words, excluding the table of contents, table of authorities, and certificates of counsel. We have relied on the word and character count of the word-processing program to prepare this certificate.

Dated this 19th day of May, 2023.

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CERTIFICATE OF SERVICE

We hereby certify that on 19th day of May, 2023, a true and correct copy of the foregoing Appellees' Brief was electronically filed via Odyssey File & Serve system, which will automatically send email notification of the same to the following:

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This matter involves a dispute over the interpretation of South Dakota Codified Law § 58-17J-2, also known as the Any Willing Provider Law (hereinafter "AWP Law"). The AWP Law was passed by the South Dakota voters as Initiated Measure 17 in 2014. Plaintiffs assert Defendant is in violation of the AWP Law by limiting the providers who may participate on some of Defendant's health plans, thereby violating the right to patient choice as to medical providers. Defendant asserts it is in compliance with the AWP Law because it allows patient choice through the various levels of health plans they offer.

This matter came before the Court on September 6, 2022, to address the parties' cross Motions for Summary Judgment. Attorneys Andrew Damgaard and Jordan Feist appeared on behalf of the Plaintiffs; Attorneys Martin Chester, Kate Middleton, and Mark Haigh appeared on behalf of the Defendant. After considering the parties' briefs, affidavits, all related filings, oral arguments, and applicable authorities, the Court issues its decision as follows.

FACTUAL BACKGROUND

Plaintiffs are independent physician groups and medical facilities located in Sioux Falls. Plaintiff Orthopedic Institute, P.C. ("Orthopedic Institute" or "OI") is a for-profit medical practice. Some of Orthopedic Institute's physicians have ownership interests in its co-plaintiff, Sioux Falls Specialty Hospital. Plaintiff Sioux Falls Specialty Hospital, L.L.P. and the "d/b/a" entities listed in the case caption (collectively, "Sioux Falls Specialty Hospital" or "SFSH") are for-profit health care entities. Plaintiffs Ophthalmology Ltd., Inc., and Ophthalmology Ltd. Eye Surgery Center, L.L.C. (collectively, "Ophthalmology Ltd.") are for-profit medical practices. Some of Ophthalmology Ltd.'s physicians also have ownership interests in co-Plaintiff Sioux Falls Specialty Hospital.

Sanford Health Plan ("SHP" or "Defendant") is a taxable non-profit corporation with its principal place of business in Sioux Falls, South Dakota. SHP is a wholly owned subsidiary of Sanford Health, a nonprofit health system. SHP has a Certificate of Authority from the South Dakota Division of Insurance to offer health benefit plans, which are offered to individuals and groups. SHP's health benefit plan contracts generally have a one-year term.

SHP offers four health benefit plans: Simplicity, Signature Series, Sanford PLUS, and Sanford TRUE. The plans cover care provided through "networks" of health care providers. A provider wishing to be "in-network" for any SHP health benefit plan must first be on SHP's

panel of providers. The SHP plans have different networks of various sizes, meaning some networks include SHP's entire panel of providers, while others consist of a smaller sub-set within the full panel, generally referred to by the parties as "focused" plans. SHP requires that each plan participant be provided the choice of either a broad or focused plan to choose from when making a plan selection either individually or through an employer.

The Simplicity Plan and Signature Series Plan are broad plans and have the greatest number of in-network providers. The Signature Series Plan is offered to large employers (those with greater than 50 employees), while the Simplicity Plan is offered to individuals and to small employers (those with 50 employees or less). Plaintiffs are all participating providers or facilities within SHP's network Signature Series and Simplicity Plans. Plaintiff Sioux Falls Specialty Hospital was permitted to participate in SHP's Simplicity Plan following Sioux Falls Specialty Hospital's prior legal action against SHP, which was resolved in a confidential settlement between the parties. See Sioux Falls Specialty Hosp., L.L.P. v. Sanford Health Plan (49 CIV. 15-899).

The Sanford TRUE Plan is a focused plan offered to individuals and to large and small employers. The "focused network" in the Sanford TRUE Plan consists of Sanford Health providers and facilities in addition to other providers necessary to meet network adequacy requirements. The TRUE Plans have no out-of-network benefits available, meaning True Plan insureds must pay completely out of pocket to treat with providers or facilities that are not in the TRUE Plan's network. Sanford PLUS is a two-tiered plan offered to large employers. Tier 1 has a narrower network of providers that, as with Sanford TRUE, consists mostly of Sanford Health providers and Sanford facilities. Tier 2 has a broader network that expands beyond the Sanford Health system and does include the Plaintiffs in this lawsuit.

To summarize, Plaintiffs are all on SHP's panel of providers, and each are in-network for the Simplicity Plan, the Signature Series Plan, and Tier 2 of the Sanford PLUS Plan. Plaintiffs are out-of-network for the Sanford TRUE Plan and Tier 1 of the Sanford PLUS Plan. Plaintiffs have requested to join the TRUE Plan network and Tier 1 of the PLUS Plan network, but SHP has denied Plaintiffs' requests. Plaintiff Ophthalmology Ltd. has turned away Sanford TRUE Plan insureds who were unable or unwilling to pay out-of-pocket for out of network treatment. Plaintiffs assert they are adequately certified and willing and able to meet SHP's terms and conditions to participate in both the Sanford TRUE Plan and Tier 1 of the Sanford PLUS Plan.

In 2014, South Dakota's Any Willing Provider Law ("AWP Law") was passed as Initiated Measure 17. The AWP Law governs a healthcare provider's eligibility to participate in a health insurer's panel of providers. The AWP law provides:

> No health insurer, including the South Dakota Medicaid program, may obstruct patient choice by excluding a health care provider licensed under the laws of this state from participating on the health insurer's panel of providers if the provider is located within the geographic coverage area of the health benefit plan and is willing and fully qualified to meet the terms and conditions of participation as established by the health insurer.

SDCL § 58-17J-2.

On September 21, 2021 Plaintiffs brought the present action seeking a declaratory judgment to enable Plaintiffs to participate as Tier 1 providers on the Sanford PLUS plan and participate on the panel of providers in the various Sanford TRUE plans. Plaintiffs also ask this Court to declare, if necessary, that the current AWP Law repeals by implication any conflicting South Dakota statutes enacted prior to the AWP Law if such prior statutes are in conflict with the language of the AWP Law.

Plaintiffs allege they are entitled to relief based on the language and purpose of the AWP Law, because pursuant to South Dakota's AWP Law: (1) the Plaintiffs are located within the geographic coverage area of the Sanford TRUE and PLUS Plans; (2) Plaintiffs are willing and fully qualified to meet the terms and conditions of participating in the large employer, small employer, and individual Sanford TRUE Plans, as well as Tier 1 of the large employer Sanford PLUS Plan network; and (3) as a result, SHP is legally required to allow Plaintiffs to participate in the Sanford TRUE Plans and Tier 1 of the large employer Sanford PLUS Plan network.

On May 6, 2022, Plaintiffs filed a Motion for Summary Judgment. Plaintiffs allege they are entitled to summary judgment as the material facts are undisputed and the application of the AWP Law is strictly a legal question for the Court. SHP filed an Opposition to Plaintiffs' Motion for Summary Judgment on July 29, 2022. In its Opposition, SHP alleged Plaintiffs do not have standing to assert a declaratory judgment claim under SDCL § 58-17J-2, and therefore that summary judgment should be denied on all claims. SHP also alleged that even if Plaintiffs had standing to sue, SHP is the party entitled to summary judgment because the undisputed facts show that SHP complies with the AWP Law.

On July 29, 2022, Defendants filed a Cross-Motion for Summary Judgment. In this Cross-Motion, SHP again argued that Plaintiffs do not have standing, and therefore summary judgment should be granted in SHP's favor as to all claims. SHP also asserts that if the Court determines that SHP's Motion for Summary Judgment should be denied, there remains genuine issues of material fact that precludes summary judgment for Plaintiffs. Defendant identifies the material issues of fact as negative consequences for SHP as a company because it would be cost-prohibitive to offer a broad plan for the lower, focused-network price, and negative

consequences for SHP insureds and individuals because it would eliminate an affordable health insurance plan option.

An analysis of the respective briefs from both sides point to three major issues that must be determined in order to rule on the summary judgment motions: first, whether Plaintiffs have standing to pursue a Declaratory Judgment Action; second, whether there are any genuine issues of material fact to preclude either party's request for summary judgment; and third, if there are no genuine issues of material fact, how to statutorily interpret the AWP Law.

LAW AND ANALYSIS

I. Standing

A standing determination is statutorily controlled. *Agar Schl Dist. No. 58-1 Brd Of Educ. V. McGee*, 527 N.W.2d 282, 284 (S.D.1995) (quoting *Wang v. Wang*, 393 N.W.2d 771, 775 (S.D. 1986)). South Dakota's Declaratory Judgment Act gives "[c]ourts of record within their respective jurisdictions ... power to declare rights, status, and other legal relations whether or not further relief is or could be claimed" and a "declaration may be either affirmative or negative in form and effect; and such declaration shall have the force and effect of a final judgment or decree." SDCL § 21-24-1. In addition, declaratory judgment relief may be allowed even when another adequate remedy exists. See *Agar Schl Dist.*, 527 N.W.2d 282. Declaratory judgment actions may be brought by

> [a]ny person ... whose rights, status, or other legal relations are affected by a *statute*, municipal ordinance, contract, or franchise, may have determined any question of construction or validity arising under the instrument, *statue*, ordinance, contract, or franchise and obtain a declaration of rights, status, or other legal relations thereunder.

SDCL § 21-24-3 (emphasis added).

The United States Supreme Court has held that a litigant must show the following in order to establish standing: "(1) an injury in fact suffered by the plaintiff, (2) a causal connection between the plaintiff's injury and the conduct of which the plaintiff complains, and (3) the likelihood that the injury will be redressed by a favorable decision *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560-61, 112 S.Ct. 2130, 2136, 119 L.Ed.2d 351 (1992). The South Dakota Supreme Court adopted this test in *Benson v. State*, 2006 S.D. 8, ¶22, 710 N.W.2d 131, 141, and recently affirmed it in *Pickeral Lake Outlet Association v. Day County,* 2020 S.D. 72, 953 N.W.2d 82 and *Abata v. Pennington County Board of Commissioners*, 931 N.W.2d 714, which are both cases involving declaratory judgment actions against the respective defendants. Whether a party has standing to pursue a declaratory judgment action is a question of law. See *Pickeral Lake*, 2020 S.D.72 at ¶ 7, 953 N.W.2d at 86 (citing *Howlett v. Stellingwerf,* 2018 S.D. 19, ¶ 11, 908 N.W.2d 775, 779).).

A. An injury in fact was suffered by the Plaintiffs.

Plaintiffs claim they have suffered actual injury in the form of lost revenue and projected financial loss, arguing that the independent medical providers have access to fewer patients because of Defendant's focused, in-network plans. Defendant disputes the Plaintiffs' rights to standing, however, noting that the Plaintiffs are merely asserting the rights of others, i.e., patients, and that Plaintiffs' financial loss is speculative and unsupported. Defendant cites to case law regarding standing as incidental or third-party beneficiaries to support their argument.[1]

[1] SHP argues the principals of contractual case law should apply to determine standing in this case, citing to *Sisney v. State*, 2008 S.D. 71, 754 N.W.2d 639 (where an inmate unsuccessfully attempted to achieve standing as a third-party beneficiary of a contract between the Department of Corrections and a food service company) and *Black Bear v. Mid-Century Education Cooperative*, 2020 S.D. 14, 941 N.W.2d 207 (where students were barred from asserting claims as third-party beneficiaries of government contracts).

A court cannot speculate as to the presence of a real injury. *Abata*, 2019 S.D. 38 at ¶ 11, 931 N.W.2d at 719. However, as demonstrated in the *Benson* and *Abata* cases, future financial loss is an injury for purposes of standing. See *Benson*, 2006 S.D. 8 at ¶ 23, 710 N.W.2d at 142 (recognizing that a statute allowing for the invasion or taking of plaintiff's property was a threatened injury for standing); *Abata*, 2019 S.D. 39 at ¶ 14, 931 N.W.2d at 719 (finding that threats of reduced property values based on a zoning ordinance was adequate for standing).

Defendant SHP is correct - Plaintiffs' injuries are not quantifiable, and Plaintiffs cannot point to any studies or evidence as to the amount of loss. Additionally, Plaintiffs only detail one specific known incident where a patient was turned away because the provider was not part of the patient's focused network panel of providers. However, the relevant case law for purposes of standing in this situation is the three-part *Benson* test as argued by the Plaintiffs, and not under an incidental beneficiary analysis pursuant to contract law as SHP suggests. Therefore, based on the relevant case law and facts of this case, an exact amount of financial injury is not required for Plaintiffs to meet the burden of showing an "actual or threatened injury" for purposes of standing. Notably, Plaintiffs have no realistic way to count the number of people who do not walk through their doors, or the types of services they were not able to provide based on their restricted access to certain SHP plans. Plaintiffs have shown they are threatened with financial injury based on the structure of providers and plans offered through SHP.

B. There is a causal connection between the Plaintiffs' injuries and the conduct Plaintiffs are asserting is unlawful.

While the parties are in dispute over whether Plaintiffs have shown an injury, it is not disputed that the Plaintiffs' alleged financial injury is causally connected to their exclusion from certain SHP plans and SHP's interpretation of the AWP Law.

C. A favorable ruling would likely redress Plaintiff's alleged injury.

As noted above, "to establish standing in a declaratory judgment action the plaintiff must have personally suffered some actual or threatened injury as the result of the putatively illegal conduct of the defendant." *Benson,* 2006 S.D. 8 at ¶ 22, 710 N.W.2d at 141 (internal citations omitted). The Plaintiffs' actual or threatened injury has been established as financial loss and the lost opportunities to increase their patient base.

Defendant SHP addresses this final prong of the standing test by alleging that Plaintiffs are not able to identify anything in their request for relief that would enhance patient choice. Defendants argue that while Plaintiffs indicate they are for patient choice, their prayer for relief in this action does not focus on patient choice. Rather, Plaintiffs request is to be given the opportunity to participate in all of SHP's plans to stop the alleged current and future financial harm to their respective businesses. The final prong requires a court to look at the likelihood that the injury will be addressed by a favorable decision. If this Court were to grant Plaintiffs summary judgment, Plaintiffs would be allowed to participate in all of SHP's plans, which would likely cure their alleged injuries.

Having considered the principles set forth by the South Dakota Supreme Court and the United States Supreme Court regarding standing, Plaintiffs have established standing in this case.

II. Summary Judgment

Because Plaintiffs have standing to pursue this lawsuit, the Court must next address whether there are genuine issues of material fact to preclude summary judgment. Summary judgment is proper "if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact, and the moving party is entitled to judgment as a matter of law." SDCL § 15-6-56(c). "A

disputed fact is not 'material' unless it would affect the outcome of the suit under the governing substantive law in that 'a reasonable jury could return a verdict for the nonmoving party.'" *Gul v. Center for Family Medicine*, 2009 S.D. 12, ¶ 8, 762 N.W.2d 629, 633 (citations omitted). "[T]he moving party has the burden of clearly demonstrating an absence of any genuine issue of material fact and an entitlement to judgment as a matter of law." *Johnson v. Matthew J. Batchelder Co., Inc.*, 2010 S.D. 23, ¶ 8, 779 N.W.2d 690, 693 (internal citations omitted). A court determining a summary judgment motion must view the facts, and all reasonable inferences drawn from the facts, most favorably to the nonmoving party. *North Star Mutual Ins. Co. v. Rasmussen*, 2007 S.D. 55, ¶ 14, 734 N.W.2d 352, 356.

Once the moving party has established its burden, the nonmoving party must "present specific facts showing that a genuine, material issue for trial exists" to evade the grant of summary judgment. *Johnson v. Hayman & Associates, Inc.*, 2015 SD. 63, ¶ 11, 867 N.W.2d 698, 701 (internal citations and quotations omitted). These specific facts must be more than "mere speculation, conjecture, or fantasy." *Stern Oil Co., Inc. v. Brown*, 2012 S.D. 56, ¶ 8, 817 N.W.2d 395, 398. "Unsupported conclusions and speculative statements do not raise a genuine issue of fact." *Dakota Indus., Inc. v. Cabela's.Com, Inc.*, 2009 S.D. 39, ¶ 20, 766 N.W.2d 510,516.

Plaintiffs assert summary judgment is proper because the material facts are undisputed, and the application of the AWP Law is a legal question for this Court. In support of their position, Plaintiffs submitted a Statement of Undisputed Material Facts that outlines that each of the Plaintiffs have board-certified providers and are within the geographic area to provide health care under SHP's plans. Counsel for the Plaintiffs has reviewed the terms and conditions of at least one of the health care plans at issue and avers that each of the Plaintiffs is able and willing to comply with those terms.

In opposition, SHP argues that granting summary judgment to Plaintiffs is improper because (1) the Plaintiffs lack standing, (2) the undisputed material facts demonstrate that SHP complies with the AWP Law, and (3) a material fact exists as to whether any of the Plaintiffs would meet the qualifications of the health plans at issue. Standing was addressed above, and statutory interpretation is a question of law. This leaves the sole question of whether there is a genuine dispute of material fact regarding Plaintiffs willingness and ability to accept the reimbursement terms under the focused plans at issue.

Throughout its submissions and during oral argument, SHP also argues that granting Plaintiffs' motion for summary judgment is not appropriate because it would have immediate and negative consequences for policy holders, and it would eliminate a low-cost insurance plan that may be the only one some people can afford. These policy arguments, while may be valid to note, are not genuine issues of material fact that would preclude summary judgment.[2]

Plaintiffs counter by reasserting that they do have standing, and that SHP cannot create a genuine issue of material fact by asserting it is unknown if the Plaintiffs are willing to accept the terms and conditions of the plans at issue by withholding the contract from Plaintiffs.

Under the AWP Law, a health provider must be "willing and fully qualified to meet the terms and conditions of participation as established by the health insurer." SDCL § 58-17J-2. Here, having reviewed the briefing and Statements of Undisputed Material Fact, there is no genuine dispute of material fact regarding Plaintiffs' qualifications and willingness to accept SHP's terms. First, Plaintiffs are willing to meet the terms and conditions of participation, as

[2] This SHP policy argument is also somewhat disingenuous. Defendant SHP claims a decision against their position would cause harm to policy holders who cannot afford a higher-cost policy, but at the same time argues that the low-cost policy complies with the AWP law because it still allows insureds who need a low-cost policy to still choose any provider by simply paying out of pocket for a provider not covered in their plan.

Plaintiffs' attorney reviewed the terms of the contract between SHP and Sanford Health and expressed Plaintiffs' willingness to meet the terms and conditions of the contract. *See* SDCL § 16-18-11 ("An attorney... has power to bind his client to any agreement in respect to any proceeding within the scope of his proper duties and powers[.]"). This is reflected in an affidavit filed by Plaintiffs' attorney. *See* Damgaard Aff., Ex. 12. Even if there is dispute between the parties about the specific terms and conditions of any one plan, such a dispute would not preclude summary judgment because it is not a material fact that would change the outcome of the court's interpretation of the AWP Law. *See Davies v. GPHC, LLC*, 2022 S.D. 55, ¶ 29 (citing *Stern Oil Co., Inc. v. Brown*, 2012 S.D. 56, ¶ 8, 817 N.W.2d 395, 398).

Second, Plaintiffs are fully qualified to meet the terms and conditions of participation in the aspect that they are all fully licensed and board certified under the laws of South Dakota. This is evidenced by Plaintiffs' Statement of Undisputed Facts, and SHP does not dispute facts related to Plaintiffs' qualifications. *See* Pls.' SUMF ¶¶ 1-22; Def.'s SUMF, ¶¶ 1-22.

Plaintiffs established their burden for summary judgment, and SHP is not able to meet its burden to produce specific, articulable facts that would preclude summary judgment. Defendant relies on policy arguments, encouraging the Court to look at the potential negative effects on insurance plan expenses and affordable care. Again, these are policy arguments, and not genuine issues of material fact. Defendant has not met its burden in response to Plaintiffs' Motion for Summary Judgment. Ultimately, there are no genuine issues of material fact and consideration of summary judgment is appropriate.

III. Statutory Interpretation

Statutory interpretation is a question of law. *Payne v. State Farm Fire & Cas.*, 2022 S.D. 3, ¶ 11, 969 N.W.2d 723, 726. "The rules of statutory construction are well settled." *State v.*

Bettelyoun, 2022 S.D. 14, ¶ 24, 972 N.W.2d 124, 131. "The purpose of statutory interpretation is to discover legislative intent." *State v. Bryant*, 2020 S.D. 49, ¶ 20, 948 N.W.2d 333, 338 (internal citation omitted). Statutory interpretation first requires an analysis of the text, and that 'we give words their plain meaning and effect, and read statutes as a whole.'" *Id.* (citing *Reck v. S.D. Bd. of Pardons & Paroles*, 2019 S.D. 42, ¶ 11, 932 N.W.2d 135, 139). "When the language in a statute is clear, certain and unambiguous, there is no reason for construction, and the Court's only function is to declare the meaning of the statute as clearly expressed." *Bettelyoun*, 2022 S.D. at ¶ 24, 972 N.W.2d at 131.

"Ambiguity 'may exist where the literal meaning of a statute leads to an absurd or unreasonable conclusion.'" *Farm Bureau Life Ins. Co. v. Dolly*, 2018 S.D. 28, ¶ 9, 910 N.W.2d 196, 200 (quoting *People ex rel J.L.*, 2011 S.D. 36, ¶ 4, 800 N.W.2d 720, 722). Ambiguity may also exist if a statute is "capable of being understood by a reasonably well-informed person in either of two or more senses[.]" *Id.* (quoting *Kling v. Stern*, 2007 S.D. 51, ¶ 6, 733 N.W.2d 615, 617). Legislative history and historical background usually provide guidance for interpretation when there is an ambiguity in a constitutional amendment. *Cummings v. Mickelson*, 495 N.W.2d 493, 498–99 (S.D. 1993); *South Dakota Auto Club Inc. v. Volk*, 305 N.W.2d 693, 697 (S.D. 1981).

The South Dakota Constitution expressly reserves to the electorate the rights to initiative and referendum. S.D. Const. art. III, § 1. Initiated or referred laws are placed on the ballot only after the sponsor complies with the provisions of SDCL § 2-1. Once a proposed measure complies with all laws required for placement on the ballot, the South Dakota Secretary of State oversees the collection of pro and con statements as well as the Attorney General's statement that will accompany the proposed measure on the ballot, in compliance with SDCL § 12-13. Once an

initiated measure is passed, "[a]ny judge must view with great deference any legislative enactment, especially when enacted by a majority of the voters of South Dakota." *SD Voice v. Noem*, 380 F.Supp.3d 939, 944 (D.S.D. 2019).

Here, the parties agree that the sole focus and intent of the statute is patient choice. The title of this Chapter, SDCL § 58-17J, is in fact "Patient Choice in Selection of Health Care Provider." To restate, the remainder of the AWP law provides:

> Patient choice – Health care provider participation
> No health insurer, including the South Dakota Medicaid program, may obstruct patient choice by excluding a health care provider licensed under the laws of this state from participating on the health insurer's panel of providers if the provider is located within the geographic coverage area of the health benefit plan and is willing and fully qualified to meet the terms and conditions of participation as established by the health insurer.

SDCL § 58-17J-2.

However, from there the Plaintiffs and Defendant each argue that the plain meaning of the text supports their respective positions, without ambiguity. Plaintiffs believe the AWP Law allows patients to choose any provider at any time under any plan, without restrictions if the providers meet the plan's geographic and reimbursement requirements. SHP argues that patients have the right to choose their provider when they elect to enroll in a certain health plan, and patients have continued freedom of choice while on a health plan to seek out any provider or specialist not included in the plan. The difference in the parties' arguments comes down to what patients have a right to choose – a provider or a plan.

It is presumed the South Dakota voters intended on enacting the statute in its plain and ordinary meaning. *See* SDCL § 2-14-1. While there are many complex collateral matters such as affordability and plan options, those were not the focus of this statute and consequently not the

focus of interpretation. Therefore, the plain language of the statute is controlling and dispositive in this case.

The statute begins by stating that patient choice should not be obstructed "by excluding a health care provider licensed under the laws ...." This is why the statute is called an "any willing provider" statute – it addresses patient choice restrictions on *providers*, not *plans*.[3] Reading further into the statute defines which providers should not be restricted: ones who are licensed under the laws of this state. To ensure patient choice, those licensed providers cannot be excluded on the health insurer's "panel of providers" if two conditions are met, (1) the provider is located in the plan's geographic coverage area, and (2) the provider is willing and qualified to meet the terms of the health plan participation.

As indicated above, all Plaintiffs are on SHP's larger panel of providers, but excluded from some of SHP's insurance benefit plans. Plaintiffs are correct that such a scheme is contrary to the plain language of the statute. The statute uses the terms "health insurer's *panel* of providers" of a "health benefit plan." The terms "panel" and "plan" are both singular, indicating the plan has a panel of providers. In other words, the panel of providers is plan-specific and not insurer-specific, and a health benefit plan has a panel of providers. Defendant SHP's position that they comply with the AWP Law because they allow Plaintiffs on at least one of their larger panel of providers does not comport with allowable reasons for excluding a provider - geographic area and meeting the plan's conditions. Defendant's interpretation would require an addition to the plain language, specifically by pluralizing "plans" (i.e., a health insurer's panel of

[3] Focus on the provider is unique to any willing provider statutes, and in contrast to other types of statutes that require insurance companies to pay for certain benefits ("mandated benefit") or statutes that require insurance companies to pay for certain treatment types ("mandated provider"). *See* Express Script, Inc. v. Wenzel, 102 F.Supp.2d 1135, 1150 (8th Cir. 2001).

providers for health benefit *plans*, or alternatively, *panels* of providers for health insurance *plans*).

Interpreting the term "panel of providers" in a plan-specific manner also comports with similar statutes under South Dakota law. SDCL § 58A-18A-53(3) defines a "closed panel plan" as "a plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan." SDCL § 58A-18A-53(3). Additionally, SDCL §58-18A-64 provides, in relevant part, that:

> Under the terms of a closed panel plan, no benefits are payable if the covered person does not use the services of a closed panel provider. No COB occurs if a covered person is enrolled in two or more closed panel plans and obtains services from a provider in one of the closed panel plans because the other closed panel plan (the one whose providers were not used) has no liability.

SDCL §58-18A-64.

Therefore, the South Dakota Legislature uses the term "panel of providers" in a plan-specific, not an insurer-specific, manner. This statutory language must be given credence, as "[t]he purpose of statutory interpretation is to discover legislative intent." *State v. Bryant*, 92020 S.D. 49, ¶ 20, 48 N.W.2d 333, 338. The Court is "bound to read our statutes sensibly if not literally." *Faircloth v. Raven Industries, Inc.*, 2000 S.D. 158, ¶ 9, 620 N.W.2d 198, 202. "When one interpretation 'would functionally annul the law, the cardinal purpose of statutory construction – ascertaining legislative intent – ought not be limited to simply reading a statute's bare language; [the Court] must also reflect upon the purpose of the enactment; the matter sought to be corrected; and the goal to be attained." *Steinberg v. S. Dakota Dep't of Mil. & Veterans Affs.*, 2000 S.D. 36, ¶ 15, 607 N.W.2d 596, 602 (quoting *DeSmet Ins. of South Dakota v. Gibson*, 1996 S.D. 102, ¶ 7, 552 N.W.2d 98, 100). Here, the general purpose of an AWP Law is to

"ensure patient choice in the selection of healthcare providers." 2015 South Dakota Laws Ch. 278 (Initiated Measure 17). This purpose cannot be conflated by adopting the alternative reading of the statute as suggested by SHP.

Defendant SHP argues that such a reading is inconsistent with 'closed plans' allowed under SDCL Title 58. However, these statutes can be harmonized because "closure" conditions can still exist but be limited as to geographic location and acceptance of reimbursement rates as allowed under the AWP Law. To the extent any prior statutes cannot be harmonized with the AWP Law, the lack of harmonization does not lead to a statutory ambiguity such that the AWP Law needs to be "liberally construe[d] ... to avoid a harsh result." *Simpson v. Tobin*, 367 N.W.2d 757, 763 (S.D. 1985). If ambiguity exists, it is a matter of clarification for the legislature. In addition, the AWP Law is the most recent in time and contains specific terms for excluding providers from health plans rather than more general terms that may be present other statutes.

CONCLUSION

Plaintiffs have established standing to present this case for declaratory judgment, in that they have alleged an injury, there is a causal connection between Plaintiffs' injury and the conduct of which Plaintiffs complain, and a favorable result would likely redress that injury. There are no genuine issues of material facts presented from either of the parties' motions for summary judgment. Upon analysis of the filings, arguments, and the whole of the record, the Court hereby:

GRANTS Plaintiffs' motion for summary judgment and DENIES Defendant's motion for summary judgment; the Court further,

DECLARES the Any Willing Provider Law enacted through Initiated Measure 17 by the voters of South Dakota does not allow a health insurer to exclude a health care provider from a

health benefit plan's panel of providers who is (1) licensed under the laws of South Dakota; (2) located within the geographic coverage area of the health benefit plan; and (3) willing and fully qualified to meet the terms and conditions of participation as established by the health insurer.

Dated this 2nd day of December, 2022.

BY THE COURT:

Rachel R. Rasmussen
Circuit Court Judge

ATTEST:
ANGELIA M. GRIES
By
Clerk/Deputy Clerk.

UNIFIED JUDICIAL SYSTEM JUSTICE STATE OF SOUTH DAKOTA

FILED
DEC 05 2022
Minnehaha County, S.D.
Clerk Circuit Court

STATE OF SOUTH DAKOTA	)	IN CIRCUIT COURT
	:SS	
COUNTY OF MINNEHAHA	)	SECOND JUDICIAL CIRCUIT

o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o

49CIV21-002622

ORTHOPEDIC INSTITUTE, P.C.; SIOUX FALLS SPECIALTY HOSPITAL, L.L.P.; SIOUX FALLS SPECIALTY HOSPITAL, L.L.P. D/B/A SIOUX FALLS URGENT CARE; SIOUX FALLS SPECIALTY HOSPITAL, L.L.P. D/B/A WORKFORCE OCCUPATIONAL HEALTH AND MEDICAL SERVICES; SIOUX FALLS SPECIALTY HOSPITAL, L.L.P. D/B/A MIDWEST PAIN SPECIALISTS; SIOUX FALLS SPECIALTY HOSPITAL, L.L.P. D/B/A MIDWEST IMAGING; OPHTHALMOLOGY LTD., INC.; and OPHTHALMOLOGY LTD. EYE SURGERY CENTER, L.L.C.,

Plaintiffs,

v.

SANFORD HEALTH PLAN, INC.,

Defendant.

ORDER GRANTING PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT AND DENYING DEFENDANT'S MOTION FOR SUMMARY JUDGMENT

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On September 6, 2022, the Court held a hearing on Plaintiffs' Motion for Summary Judgment and on Defendant's Motion for Summary Judgment. Andrew Damgaard and Jordan Feist appeared on behalf of Plaintiffs, and Martin Chester, Kate Middleton, and Mark Haigh appeared on behalf of Defendant. The Court issued a Memorandum Opinion Granting Plaintiffs' Motion for Summary Judgment and Denying Defendant's Motion for Summary Judgment dated

December 2, 2022, which was filed on December 5, 2022, and which is attached hereto as Exhibit A and incorporated herein by reference as if fully set forth.

Having considered the written submission of the parties and the arguments of counsel, it is hereby:

ORDERED, ADJUDGED, AND DECREED that there are no genuine issues of material fact and that Plaintiffs are entitled to judgment as a matter of law; it is further

ORDERED, ADJUDGED, AND DECREED that Plaintiffs' Motion for Summary Judgment is GRANTED; it is further

ORDERED, ADJUDGED, AND DECREED that Defendant's Motion for Summary Judgment is DENIED; it is further

ORDERED, ADJUDGED, AND DECREED that the Any Willing Provider Law enacted through Initiated Measure 17 by the voters of South Dakota does not allow a health insurer to exclude a health care provider from a health benefit plan's panel of providers who is (1) licensed under the laws of South Dakota; (2) located within the geographic coverage area of the health benefit plan; and (3) willing and fully qualified to meet the terms and conditions of participation as established by the health insurer.

12/27/2022 2:01:29 PM

BY THE COURT:

Rachel R. Rasmussen, Circuit Court Judge

Attest:
Russell, Lisa
Clerk/Deputy

STATE OF SOUTH DAKOTA	)	IN CIRCUIT COURT
	:SS	
COUNTY OF MINNEHAHA	)	SECOND JUDICIAL CIRCUIT

o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o

49CIV21-002622

ORTHOPEDIC INSTITUTE, P.C.; SIOUX FALLS SPECIALTY HOSPITAL, L.L.P.; SIOUX FALLS SPECIALTY HOSPITAL, L.L.P. D/B/A SIOUX FALLS URGENT CARE; SIOUX FALLS SPECIALTY HOSPITAL, L.L.P. D/B/A WORKFORCE OCCUPATIONAL HEALTH AND MEDICAL SERVICES; SIOUX FALLS SPECIALTY HOSPITAL, L.L.P. D/B/A MIDWEST PAIN SPECIALISTS; SIOUX FALLS SPECIALTY HOSPITAL, L.L.P. D/B/A MIDWEST IMAGING; OPHTHALMOLOGY LTD., INC.; and OPHTHALMOLOGY LTD. EYE SURGERY CENTER, L.L.C.,

Plaintiffs,

v.

SANFORD HEALTH PLAN, INC.,

Defendant.

AFFIDAVIT OF LYNDA BARRIE

o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o

STATE OF SOUTH DAKOTA	)	
	: SS	
COUNTY OF MINNEHAHA	)	

Lynda Barrie, being first duly sworn, states as follows:

1. I am the Chief Executive Officer of Orthopedic Institute, P.C ("OI").

2. OI's principal place of business is in Sioux Falls, South Dakota.

Appellees' Appendix 021

Filed: 5/6/2022 4:04 PM CST Minnehaha County, South Dakota 49CIV21-002622

3. OI is an orthopedic practice group made up of 19 physicians, 18 physician assistants, and 2 nurse practitioners.

4. OI also employs physical and occupational therapists.

5. All of OI's medical providers are licensed by the South Dakota Board of Medical and Osteopathic Examiners or by the South Dakota Board of Nursing.

6. Most of OI's medical providers are licensed in multiple states.

7. 15 of OI's physicians are certified by the American Board of Orthopedic Surgery and 1 of OI's physicians is certified by the American Osteopathic Board of Orthopedic Surgery.

8. 2 of OI's physicians are certified by the American Board of Anesthesiology.

9. 1 of OI's physicians is board certified by the American Board of Electrodiagnostic Medicine.

10. All of OI's physicians have privileges with multiple hospitals in Sioux Falls.

11. OI and its predecessor entities have been providing orthopedic care to patients for decades.

12. OI is a credentialed with Sanford Health Plan and is a participating provider group in Sanford Health Plan's broad network Signature Series and Simplicity plans.

13. OI is willing to meet Sanford Health Plan's terms and conditions so as to be a participating provider in Sanford Health Plan's individual, small group and large group True Plans.

14. OI is willing to meet Sanford Health Plan's terms and conditions so as to be a tier 1 participating provider in Sanford Health Plan's large group Plus Plan.

15. OI has requested to be a participating provider in Sanford Health Plan's True Plan in the past, but Sanford Health Plan denied OI's request.

Dated this 3 day of May, 2022.

Lynda Barrie

Subscribed and sworn to before me
this 3rd day of May, 2022.

Melissa Edwards
Notary Public – South Dakota

4.7.27

MELISSA EDWARDS
NOTARY PUBLIC
SOUTH DAKOTA
SEAL SEAL

CERTIFICATE OF SERVICE

I hereby certify that on this 6th day of May, 2022, a true and correct copy of the foregoing was electronically served through the Odyssey File and Serve system upon the following individuals:

Via Odyssey and Email:

Mark W. Haigh
Delia M. Druley
101 N. Main Avenue, Suite 213
PO Box 2790
Sioux Falls, SD 57101
mhaigh@ehhlawyers.com
ddruley@ehhlawyers.com
Attorneys for Defendant

Via Email:

Martin S. Chester
Adam J. Pabarcus
Josiah D. Young
2200 Wells Fargo Center
90 South Seventh Street
Minneapolis, MN 55402-3901
martin.chester@faegredrinker.com
adam.pabarcus@faegredrinker.com
josiah.young@faegredrinker.com
Attorneys for Defendant

/s/ Andrew R. Damgaard
One of the Attorneys for Plaintiff

Filed: 5/6/2022 4:04 PM CST Minnehaha County, South Dakota 49CIV21-002622

STATE OF SOUTH DAKOTA	)	IN CIRCUIT COURT
	:SS	
COUNTY OF MINNEHAHA	)	SECOND JUDICIAL CIRCUIT

o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o

ORTHOPEDIC INSTITUTE, P.C.; SIOUX FALLS SPECIALTY HOSPITAL, L.L.P.; SIOUX FALLS SPECIALTY HOSPITAL, L.L.P. D/B/A SIOUX FALLS URGENT CARE; SIOUX FALLS SPECIALTY HOSPITAL, L.L.P. D/B/A WORKFORCE OCCUPATIONAL HEALTH AND MEDICAL SERVICES; SIOUX FALLS SPECIALTY HOSPITAL, L.L.P. D/B/A MIDWEST PAIN SPECIALISTS; SIOUX FALLS SPECIALTY HOSPITAL, L.L.P. D/B/A MIDWEST IMAGING; OPHTHALMOLOGY LTD., INC.; and OPHTHALMOLOGY LTD. EYE SURGERY CENTER, L.L.C.,	:	49CIV21-002622
Plaintiffs,	:	**AFFIDAVIT OF MARTY APPELHOF**
v.	:	
SANFORD HEALTH PLAN, INC.,	:	
Defendant.	:	

o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o

STATE OF SOUTH DAKOTA	)	
	: SS	
COUNTY OF MINNEHAHA	)	

Marty Appelhof, being first duly sworn, states as follows:

1. I am the Chief Financial Officer of Sioux Falls Specialty Hospital, LLP ("SFSH").

2. SFSH's principal place of business is in Sioux Falls, South Dakota.

3. SFSH has a facility capacity of 48 rooms and has been operating for over three decades.

Filed: 5/6/2022 4:04 PM CST Minnehaha County, South Dakota 49CIV21-002622

4. SFSH is licensed with the South Dakota Department of Health. A true and correct copy of SFSH's license is attached hereto as **Exhibit A**.

5. SFSH provides many services, including, but not limited to inpatient and outpatient surgical services.

6. SFSH d/b/a Sioux Falls Urgent Care operates an urgent care facility and provides urgent care medical services in Sioux Falls.

7. SFSH d/b/a Workforce Occupational Health and Medical Services operates an occupational medicine facility and provides occupational medicine services in two locations in Sioux Falls.

8. SFSH d/b/a Midwest Pain Specialists operates a pain management facility and provides pain management services in Sioux Falls.

9. SFSH d/b/a Midwest Imaging operates an imaging facility and provides imaging services, including but not limited to magnetic resonance imaging ("MRI") in Sioux Falls.

10. All of SFSH's employed medical providers are board certified and licensed by the South Dakota Board of Medical and Osteopathic Examiners or by the South Dakota Board of Nursing.

11. SFSH is a credentialed health care facility with Sanford Health Plan.

12. SFSH is a participating facility in Sanford Health Plan's broad network Signature Series and Simplicity Plans.

13. SFSH is willing to meet Sanford Health Plan's terms and conditions so as to be a participating provider in Sanford Health Plan's individual, small group and large group True Plans.

14. SFSH is willing to meet Sanford Health Plan's terms and conditions so as to be a tier 1 participating provider in Sanford Health Plan's large group Plus Plan.

15. Independent Health Care Associates, Inc., on behalf of SFSH, requested to be a participating facility in Sanford Health Plan's True Plan in the past, but Sanford Health Plan denied that request.

Dated this 29 day of April, 2022.

Marty Appelhof

Subscribed and sworn to before me
this 29 day of April, 2022.

Notary Public – South Dakota

KRISTY LESLIE
SEAL NOTARY PUBLIC SOUTH DAKOTA SEAL

My Commission Expires 3/2/24

CERTIFICATE OF SERVICE

I hereby certify that on this 6th day of May, 2022, a true and correct copy of the foregoing was electronically served through the Odyssey File and Serve system upon the following individuals:

Via Odyssey and Email:

Mark W. Haigh
Delia M. Druley
101 N. Main Avenue, Suite 213
PO Box 2790
Sioux Falls, SD 57101
mhaigh@ehhlawyers.com
ddruley@ehhlawyers.com
Attorneys for Defendant

Via Email:

Martin S. Chester
Adam J. Pabarcus
Josiah D. Young
2200 Wells Fargo Center
90 South Seventh Street
Minneapolis, MN 55402-3901
martin.chester@faegredrinker.com
adam.pabarcus@faegredrinker.com
josiah.young@faegredrinker.com
Attorneys for Defendant

/s/ Andrew R. Damgaard
One of the Attorneys for Plaintiff

Filed: 5/6/2022 4:04 PM CST Minnehaha County, South Dakota 49CIV21-002622

South Dakota
Department of Health
Specialized Hospital License

Issued To: Sioux Falls Specialty Hospital, L.L.P.

License Number
10583

Located At: Sioux Falls Specialty Hospital, L.L.P.
910 E 20th St
Sioux Falls, SD 57105-1012

Effective Date
07/01/2021

#-Beds
33

#-Swing Beds
0

1. Limited to Inpatient and Outpatient Surgical Services and Medical Services. 2. Practice location: Midwest Imaging/Midwest Pain Specialists-716 E 19th St.

Expires

06/30/2022

Kim Malsam-Rysdon

Secretary of Health

Note: This License must be posted in a conspicuous place on the premises.

Appellees' Appendix 029

EXHIBIT
A

STATE OF SOUTH DAKOTA	)	IN CIRCUIT COURT
	:SS	
COUNTY OF MINNEHAHA	)	SECOND JUDICIAL CIRCUIT

o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o

ORTHOPEDIC INSTITUTE, P.C.; SIOUX FALLS SPECIALTY HOSPITAL, L.L.P.; SIOUX FALLS SPECIALTY HOSPITAL, L.L.P. D/B/A SIOUX FALLS URGENT CARE; SIOUX FALLS SPECIALTY HOSPITAL, L.L.P. D/B/A WORKFORCE OCCUPATIONAL HEALTH AND MEDICAL SERVICES; SIOUX FALLS SPECIALTY HOSPITAL, L.L.P. D/B/A MIDWEST PAIN SPECIALISTS; SIOUX FALLS SPECIALTY HOSPITAL, L.L.P. D/B/A MIDWEST IMAGING; OPHTHALMOLOGY LTD., INC.; and OPHTHALMOLOGY LTD. EYE SURGERY CENTER, L.L.C.,	:	49CIV21-002622
Plaintiffs,	:	**AFFIDAVIT OF STAN GEBHART**
v.	:	
SANFORD HEALTH PLAN, INC.,	:	
Defendant.	:	

o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o

STATE OF SOUTH DAKOTA	)	
	: SS	
COUNTY OF MINNEHAHA	)	

Stan Gebhart, being first duly sworn, states as follows:

1. I am the lead administrator at Ophthalmology Ltd, Inc. and Ophthalmology Ltd Eye Surgery Center, LLC.

2. Ophthalmology Ltd, Inc.'s principal place of business is in Sioux Falls, South Dakota.

Filed: 5/6/2022 4:04 PM CST Minnehaha County, South Dakota 49CIV21-002622

3. Ophthalmology Ltd is a group of eye surgeons and optometrists that provide eye care services.

4. All of Ophthalmology Ltd's medical providers are licensed by the South Dakota Board of Medical and Osteopathic Examiners or by the South Dakota Board of Examiners in Optometry.

5. All of Ophthalmology Ltd's medical providers are board certified by either the American Academy of Ophthalmology or the American Optometric Association.

6. For over fifty-years, Ophthalmology Ltd has provided comprehensive medical and surgical eye care, including treatment for cataracts, glaucoma, diabetic eye disease, as well as cornea transplants, oculoplastic surgery, retinal surgery, vitreoretinal retinal surgery, and pediatric eye care.

7. Ophthalmology Ltd is credentialed with Sanford Health Plan and was credentialed with its predecessor, Sioux Valley Health Plan.

8. Ophthalmology Ltd is a participating provider group in Sanford Health Plan's broad network Signature Series and Simplicity plans.

9. Ophthalmology Ltd is not a participating group in the Sanford True Plan and has had to turn away patients that are not willing and able to pay 100% out-of-pocket for treatment.

10. When I made Sanford Health Plan aware of this issue, I was informed that Ophthalmology Ltd is not in-network for the Sanford True Plan.

11. Ophthalmology Ltd is willing to meet Sanford Health Plan's terms and conditions so as to be a participating provider in Sanford Health Plan's individual, small group and large group True Plans.

12. Ophthalmology Ltd is willing to meet Sanford Health Plan's terms and conditions so as to be a tier 1 participating provider in Sanford Health Plan's large group Plus Plan.

13. Ophthalmology Ltd Eye Surgery Center is an ambulatory eye surgery center where Ophthalmology Ltd's sub-specialty eye surgeons perform surgeries.

14. Ophthalmology Ltd Eye Surgery Center is licensed with the South Dakota Department of Health. A true and correct copy of the license is attached as **Exhibit A**.

15. Ophthalmology Ltd Eye Surgery Center is a credentialed health care facility with Sanford Health Plan.

16. Ophthalmology Ltd Eye Surgery Center is a participating facility in Sanford Health Plan's broad network Signature Series and Simplicity Plans.

17. Ophthalmology Ltd Eye Surgery Center is willing to meet Sanford Health Plan's terms and conditions so as to be a participating provider in Sanford Health Plan's individual, small group and large group True Plans.

18. Ophthalmology Ltd is willing to meet Sanford Health Plan's terms and conditions so as to be a tier 1 participating provider in Sanford Health Plan's large group Plus Plan.

Dated this 21 day of April, 2022.

Stan Gebhart

Subscribed and sworn to before me
this 21st day of April, 2022.

Notary Public - South Dakota

MINDY SLENDY
NOTARY PUBLIC
SOUTH DAKOTA
SEAL

expires 5/16/2025

CERTIFICATE OF SERVICE

I hereby certify that on this 6th day of May, 2022, a true and correct copy of the foregoing was electronically served through the Odyssey File and Serve system upon the following individuals:

Via Odyssey and Email:

Mark W. Haigh
Delia M. Druley
101 N. Main Avenue, Suite 213
PO Box 2790
Sioux Falls, SD 57101
mhaigh@ehhlawyers.com
ddruley@ehhlawyers.com
Attorneys for Defendant

Via Email:

Martin S. Chester
Adam J. Pabarcus
Josiah D. Young
2200 Wells Fargo Center
90 South Seventh Street
Minneapolis, MN 55402-3901
martin.chester@faegredrinker.com
adam.pabarcus@faegredrinker.com
josiah.young@faegredrinker.com
Attorneys for Defendant

/s/ Andrew R. Damgaard
One of the Attorneys for Plaintiff

South Dakota
Department of Health
Ambulatory Surgery Center License

License Number
41051

Issued To: Ophthalmology Ltd. Eye Surgery Center, LLC

Located At: Ophthalmology LTD Eye Surgery Center LLC
6601 S. Minnesota Ave., Ste 100
Sioux Falls, SD 57108-2563

Effective Date
07/01/2021

#-Recovery Stations
8

#-Surgical Rooms
2

Expires
06/30/2022

Kim Malsam-Rysdon
Secretary of Health

Note: This License must be posted in a conspicuous place on the premises.

EXHIBIT
Appendix 034

STATE OF SOUTH DAKOTA	)	IN CIRCUIT COURT
	:SS	
COUNTY OF MINNEHAHA	)	SECOND JUDICIAL CIRCUIT

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Case Number: _____

ORTHOPEDIC INSTITUTE, P.C.; SIOUX FALLS SPECIALTY HOSPITAL, L.L.P.; SIOUX FALLS SPECIALTY HOSPITAL, L.L.P. D/B/A SIOUX FALLS URGENT CARE; SIOUX FALLS SPECIALTY HOSPITAL, L.L.P. D/B/A WORKFORCE OCCUPATIONAL HEALTH AND MEDICAL SERVICES; SIOUX FALLS SPECIALTY HOSPITAL, L.L.P. D/B/A MIDWEST PAIN SPECIALISTS;SIOUX FALLS SPECIALTY HOSPITAL, L.L.P. D/B/A MIDWEST IMAGING; OPHTHALMOLOGY LTD., INC.; and OPHTHALMOLOGY LTD. EYE SURGERY CENTER, L.L.C.,

Plaintiffs,

v.

SANFORD HEALTH PLAN, INC.,

Defendant.

COMPLAINT

o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o

INTRODUCTION

In 2014, South Dakota's voters overwhelmingly passed Initiated Measure 17, which prohibits health insurers from excluding health care providers from participating in the insurer's health insurance plans if the health care provider is (1) located within the geographic coverage area of the health insurance plan and (2) is willing and fully qualified to

meet the terms and conditions of participation established by the health insurer. Initiated Measure 17, now codified as SDCL § 58-17J-2, is South Dakota's Any Willing Provider Law ("AWP law"). When it passed, South Dakota joined more than one-half of the states in America that have enacted AWP laws aimed at prohibiting health insurers from engaging in monopolistic and anti-competitive practices.

Unfortunately, South Dakota's AWP law has not deterred Defendant Sanford Health Plan from creating, maintaining, and marketing health insurance plans that either restrict or significantly limit insureds and their family members from treating with any health care provider outside of the Sanford Health network. The result of the restricted health plans is a vertically integrated monopoly where Sanford Health Plan acts as the insurer and collects the premiums from the policies while requiring its insureds and their families to treat entirely within the Sanford Health network. Unlike an insurer that is not also in the business of providing health care services, when Sanford Health Plan pays claims under its restricted plans, Sanford Health Plan effectively is paying itself.

In addition to gaining an advantage over its competitors in the *health insurance market*, Sanford Health also gains an advantage over its competitors in the *health care market*. As the restricted health plans acquire more and more members, the few remaining independent medical providers have access to fewer and fewer patients. The Plaintiffs believe Sanford's goal in this regard is to force independent providers to either be acquired by Sanford or to face eventual economic ruin.

This action simply seeks declaratory judgments that the Plaintiffs be allowed to participate in two specific plans under the same terms and conditions as Sanford Health's providers. If successful in this action, the Plaintiffs will be reimbursed for services at the same rate that Sanford Health Plan reimburses Sanford Health's medical providers and facilities. Accordingly, there will be no competition between the Plaintiffs and Sanford Health *with respect to cost.* Instead, allowing the Plaintiffs access to the restricted plans will create competition between the Plaintiffs and Sanford Health for the *quality of care they provide*—which is the outcome South Dakota voters desired when they overwhelmingly voted for the AWP law.

COMPLAINT

The Plaintiffs, Orthopedic Institute, P.C. ("OI"), Sioux Falls Specialty Hospital, L.L.P. ("SFSH"), Ophthalmology Ltd., Inc., and Ophthalmology Ltd. Eye Surgery Center, L.L.C., state and allege as follows in support of their Complaint:

PARTIES

1. Plaintiff OI is a South Dakota professional corporation. OI's principal place of business is in Sioux Falls, Minnehaha County, South Dakota. OI is a licensed health care provider as defined by SDCL § 58-17F-1(9). OI has been providing orthopedic care to patients for over 50 years and consumers voted OI as the #1 Orthopedics & Sports Medicine practice in the Sioux Falls metro area.

2. Plaintiff SFSH is a South Dakota Limited Liability Partnership. SFSH's principal place of business is in Sioux Falls, Minnehaha County, South Dakota. SFSH is a licensed health care provider as defined by SDCL § 58-17F-1(9). SFSH is a 48-bed hospital that has been operating for over 35 years. SFSH provides many types of services, including, but not limited to, inpatient and outpatient surgical services. SFSH and Avera Heart Hospital of South Dakota are the only 5 star patient survey rated hospitals in the Sioux Falls metro area.

3. Plaintiff SFSH d/b/a Sioux Falls Urgent Care is a division of Plaintiff SFSH that operates an urgent care facility and provides urgent care medical services in Sioux Falls, Lincoln County, South Dakota.

4. Plaintiff SFSH d/b/a Workforce Occupational Health and Medical Services ("SFSH d/b/a Workforce") is a division of Plaintiff SFSH that operates an occupational medicine facility and provides occupational medicine services in two locations in Sioux Falls, one of which is located in Minnehaha County and the other in Lincoln County.

5. Plaintiff SFSH d/b/a Midwest Pain Specialists ("SFSH d/b/a Midwest Pain") is a division of SFSH that operates a pain management facility and provides pain management medical services in Sioux Falls, Minnehaha County, South Dakota.

6. Plaintiff SFSH d/b/a Midwest Imaging is a division of SFSH that operates an imaging facility and provides imaging services, including but not limited to magnetic

resonance imaging ("MRI"). SFSH d/b/a Midwest Imaging is located in Sioux Falls, Minnehaha County, South Dakota.

7. Plaintiff Ophthalmology Ltd., Inc. ("Ophthalmology Ltd.") is a South Dakota Corporation with its principal place of business in Sioux Falls, Lincoln County, South Dakota. Ophthalmology Ltd. is a licensed health care provider as defined by SDCL § 58-17F-1(9). For over fifty-years, Ophthalmology Ltd. Has provided comprehensive medical and surgical eye care, including treatment for cataracts, glaucoma, diabetic eye disease, as well as cornea transplants, oculoplastic surgery, retinal surgery, vitreoretinal retinal surgery, and pediatric eye care.

8. Plaintiff Ophthalmology Ltd. Eye Surgery Center, L.L.C. (the "Eye Surgery Center") is a South Dakota Limited Liability Company with its principal place of business in Sioux Falls, Lincoln County, South Dakota. The Eye Surgery Center is a licensed health care provider as defined by SDCL § 58-17F-1(9). The Eye Surgery Center is an ambulatory surgery center where Plaintiff Ophthalmology Ltd's sub-specialty eye surgeons perform surgeries.

9. Defendant Sanford Health Plan, Inc. ("SHP") is a South Dakota non-profit corporation. SHP's principal place of business is in Sioux Falls, Minnehaha County, South Dakota.

FACTS

10. Sanford Health is a South Dakota non-profit corporation.

11. Sanford Health is the largest rural non-profit health care system in the nation.

12. SHP is a wholly owned subsidiary of Sanford Health.

13. SHP is a health insurer licensed by and subject to the regulation of the South Dakota Division of Insurance.

14. SHP sells health insurance plans to employers and individuals on and off the Health Insurance Marketplace/Health Care Exchange.

LARGE EMPLOYER PLANS

15. SHP's large employer plans are marketed to employers with 51 or more employees.

16. SHP offers three types of health plans to large employers: Sanford Signature Series, Sanford Plus, and Sanford True.

17. Sanford Signature Series is a broad plan that allows insureds to choose their own providers, including specialists, without a referral.

18. The Plaintiffs are participating providers in the Sanford Signature Series Plans.

SANFORD PLUS PLAN—LARGE EMPLOYER

19. The Sanford Plus Plan is a Preferred Provider Organization ("PPO") Plan that has tier 1 and tier 2 providers.

20. Employees and their families that are insured by the Sanford Plus Plan are offered financial incentives to treat with tier 1 providers.

21. If an employee or one of the employee's family members insured by the Sanford Plus Plan desires to treat with a tier 2 provider, they must get pre-approval from SHP.

22. Even if the insured is approved to treat with a tier 2 provider, the insured is required to pay twice as much as the tier 1 deductible, 20% more than the tier 1 co-insurance, and a higher copay than the tier 1 copay.

23. Plaintiffs are tier 2 providers in the Sanford Plus Plan.

24. The only orthopedic-related health care providers allowed to participate in tier 1 of the Sanford Plus Plan's panel of orthopedic providers are Sanford Health providers, including Sanford Orthopedics and Sports Medicine, Sanford Physical Medicine and Rehabilitation, and Sanford Health Midtown Clinic.

25. The only hospitals allowed to participate in tier 1 of the Sanford Plus Plan's panel of facilities providers are Sanford Health hospitals and facilities, including Sanford USD Medical Center.

26. The only urgent care providers allowed to participate in tier 1 of the Sanford Plus Plan's panel of urgent care providers are Sanford Health providers, including Sanford Health Acute Care.

27. The only occupational medicine providers allowed to participate in tier 1 of the Sanford Plus Plan's occupational medicine panel of providers are Sanford Health providers, including Sanford Occupational Medicine Clinic.

28. The only pain management providers allowed to participate in tier 1 of the Sanford Plus Plan's pain management panel of providers are Sanford Health providers, including Sanford Physical Medicine and Rehabilitation.

29. The only imaging providers allowed to participate in tier 1 of the Sanford Plus Plan's imaging panel of providers are Sanford Health providers, including Sanford Clinic Radiology.

30. The only optometrists allowed to participate in tier 1 of the Sanford Plus Plan's optometry panel of providers are Sanford Health providers, including Sanford Eye Center and Optical.

31. The only ophthalmologists allowed to participate in tier 1 of the Sanford Plus Plan's ophthalmology panel of providers are Sanford Health providers, including Sanford Clinic Ophthalmology and Sanford Eye Center and Optical.

32. The only facilities engaged in eye surgeries allowed to participate in tier 1 of the Sanford Plus Plan's panel of facilities providers are Sanford Health providers, including Sanford USD Medical Center.

33. The service area of the Sanford Plus Plan includes South Dakota, North Dakota, and approved counties in Minnesota and Iowa.

34. Plaintiff OI is willing and fully qualified to meet the terms and conditions SHP has with the Sanford orthopedists so as to participate on the tier 1 panel of providers in the Sanford Plus Plan.

35. Plaintiff SFSH is willing and fully qualified to meet the terms and conditions SHP has with Sanford's hospitals, including Sanford USD Medical Center, so as to participate on the tier 1 panel of providers in the Sanford Plus Plan.

36. Plaintiff SFSH d/b/a Sioux Falls Urgent Care is willing and fully qualified to meet the terms and conditions SHP has with Sanford Acute Care so as to participate on the tier 1 panel of providers in the Sanford Plus Plan.

37. Plaintiff SFSH d/b/a Workforce is willing and fully qualified to meet the terms and conditions SHP has with Sanford Occupational Medicine Clinic so as to participate on the tier 1 panel of providers in the Sanford Plus Plan.

38. Plaintiff SFSH d/b/a Midwest Pain is willing and fully qualified to meet the terms and conditions SHP has with Sanford Physical Medicine and Rehabilitation so as to participate on the tier 1 panel of providers in the Sanford Plus Plan.

39. Plaintiff SFSH d/b/a Midwest Imaging is willing and fully qualified to meet the terms and conditions SHP has with Sanford Clinic Radiology so as to participate on the tier 1 panel of providers in the Sanford Plus Plan.

40. Plaintiff Ophthalmology Ltd. is willing and fully qualified to meet the terms and conditions SHP has with Sanford Eye Center and Optical so as to participate on the tier 1 panel of providers in the Sanford Plus Plan.

41. Plaintiff Eye Surgery Center is willing and fully qualified to meet the terms and conditions SHP has with its eye surgery facilities, including Sanford USD Medical Center, so as to participate on the tier 1 panel of providers in the Sanford Plus Plan.

SANFORD TRUE PLAN—LARGE EMPLOYER

42. In addition to the Sanford Signature Series and Sanford Plus Plans, SHP also sells the Sanford True Plan to large employers.

43. SHP, through its agents, brokers, and representatives, markets the Sanford True Plan to large employers and represents that the Sanford True Plan saves approximately 20% in premium savings compared to the Sanford Signature Series Plan, which, as outlined above, is the only large employer Plan that SHP has allowed independent providers like the Plaintiffs to participate in on an equal basis.

44. Employers are shown graphs and other data by SHP agents, brokers, and representatives that promote the Sanford True Plan over the Sanford Signature Series Plan in terms of long term savings.

45. The Sanford True Plan does not compete with the Sanford Plus Plan because Sanford will not permit employers to offer the Sanford True Plan as a side by side to the Sanford Plus Plan. Instead, employers are required to offer Sanford Plus and Sanford Signature Series Plans as side by sides or the Sanford True and Sanford Signature Series Plans as side by sides.

46. The only non-chiropractic, orthopedic-related health care providers allowed to participate in the large employer Sanford True Plan's panel of orthopedic providers are Sanford Health providers, including Sanford Orthopedics and Sports Medicine, Sanford Physical Medicine and Rehabilitation, and Sanford Health Midtown Clinic.

47. The only hospitals allowed to participate in the Sanford True Plan's panel of hospital and facilities providers are Sanford Health hospitals and facilities, including Sanford USD Medical Center.

48. The only urgent care providers allowed to participate in the large employer Sanford True Plan's panel of urgent care providers are Sanford Health providers, including Sanford Health Acute Care.

49. The only occupational medicine providers allowed to participate in the large employer Sanford True Plan's panel of occupational medicine providers are Sanford Health providers, including Sanford Occupational Medicine Clinic.

50. The only pain management providers allowed to participate in the large employer Sanford True Plan's pain management panel of providers are Sanford Health providers, including Sanford Physical Medicine and Rehabilitation.

51. The only imaging providers allowed to participate on the large employer Sanford True Plan's imaging providers are Sanford Health providers, including Sanford Clinic Radiology.

52. The only ophthalmologists allowed to participate in the large employer Sanford True Plan are Sanford Health Providers, including Sanford Eye Center and Optical.

53. SHP does not allow Plaintiff Ophthalmology Ltd.'s optometrists to participate in the large employer Sanford True Plan.

54. SHP does, however, allow a number of independent optometrists in the Sioux Falls metro area to participate in the large employer Sanford True Plan.

55. Upon information and belief, SHP does so because their insureds are forced to pay 100% out of pocket if an optometrist refers the insured to an independent ophthalmologist for treatment or a surgical procedure.

56. Upon information and belief, this results in almost all large employer Sanford True Plan insureds being treated by Sanford ophthalmologists, regardless of whether the optometrist initially referred the insured to Plaintiff Ophthalmology Ltd. or another independent ophthalmology provider.

57. The service area for the large employer Sanford True Plan consists of South Dakota, North Dakota, and approved counties in Minnesota and Iowa.

58. Plaintiff OI is willing and fully qualified to meet the terms and conditions SHP has with the Sanford orthopedists so as to participate on the panel of providers in the large employer Sanford True Plan.

59. Plaintiff SFSH is willing and fully qualified to meet the terms and conditions SHP has with Sanford's hospitals, including Sanford USD Medical Center, so as to participate on the panel pf providers in the large employer Sanford True Plan.

60. Plaintiff SFSH d/b/a Sioux Falls Urgent Care is willing and fully qualified to meet the terms and conditions SHP has with Sanford Acute Care so as to participate on the panel of providers in the large employer Sanford True Plan.

61. Plaintiff SFSH d/b/a Workforce is willing and fully qualified to meet the terms and conditions SHP has with Sanford Occupational Medicine Clinic so as to participate on the panel of providers in the large employer Sanford True Plan.

62. Plaintiff SFSH d/b/a Midwest Pain is willing and fully qualified to meet the terms and conditions SHP has with Sanford Physical Medicine and Rehabilitation so as to participate on the panel of providers in the large employer Sanford True Plan.

63. Plaintiff SFSH d/b/a Midwest Imaging is willing and fully qualified to meet the terms and conditions SHP has with Sanford Clinic Radiology so as to participate on the panel of providers in the large employer Sanford True Plan.

64. Plaintiff Ophthalmology Ltd. is willing and fully qualified to meet the terms and conditions SHP has with Sanford Eye Center and Optical so as to participate on the panel of providers in the large employer Sanford True Plan.

65. Plaintiff Eye Surgery Center is willing and fully qualified to meet the terms and conditions SHP has with its eye surgery facilities, including Sanford USD Medical Center, so as to participate on the panel of providers in the large employer Sanford True Plan.

SMALL EMPLOYER PLANS

66. SHP's small employer health insurance plans are sold to employers with 50 or less employees.

67. SHP sells two health insurance plans to small employers: the Sanford Simplicity Plan and the Sanford True Plan.

68. The Sanford Simplicity Plan is a broad plan that allows insureds to choose their own providers, including specialists, without a referral.

69. The Plaintiffs are participating providers in the Sanford Simplicity Plan.

SANFORD TRUE PLAN—SMALL EMPLOYER

70. In addition to the Sanford Simplicity Plan, SHP markets and sells small employers the Sanford True Plan.

71. SHP, through its agents, brokers, and representatives, markets the Sanford True Plan to small employers and represents that the Sanford True Plan saves approximately 20% in premium savings compared to the Sanford Simplicity Plan.

72. Employers are shown graphs and other data by SHP agents, brokers, and representatives that promote the Sanford True Plan over the Sanford Simplicity Plan in terms of long-term savings.

73. The only non-chiropractic, orthopedic-related health care providers allowed to participate on the small employer Sanford True Plan's panel of orthopedic providers are Sanford Health providers, including Sanford Orthopedics and Sports Medicine, Sanford Physical Medicine and Rehabilitation, and Sanford Health Midtown Clinic.

74. The only hospitals allowed to participate on the small employer Sanford True Plan's panel of hospital and facilities providers are Sanford Health hospitals and facilities, including Sanford USD Medical Center.

75. The only urgent care providers allowed to participate on the small employer Sanford True Plan's panel of urgent care providers are Sanford Health providers, including Sanford Health Acute Care.

76. The only occupational medicine providers allowed to participate on the small employer Sanford True Plan's occupational medicine panel of providers are Sanford Health providers, including Sanford Occupational Medicine Clinic.

77. The only pain management providers allowed to participate on the small employer Sanford True Plan's pain management panel of providers are Sanford Health providers, including Sanford Physical Medicine and Rehabilitation.

78. The only imaging providers allowed to participate on the small employer Sanford True Plan's imaging panel of providers are Sanford Health providers, including Sanford Clinic Radiology.

79. The only ophthalmologists allowed to participate in the small employer Sanford True Plan are Sanford Health Providers, including Sanford Eye Center and Optical.

80. SHP does not allow Plaintiff Ophthalmology Ltd.'s optometrists to participate in the small employer Sanford True Plan.

81. SHP does, however, allow a number of independent optometrists in the Sioux Falls metro area to participate in the small employer Sanford True Plan.

82. Upon information and belief, SHP does so because their insureds are forced to pay 100% out of pocket if an optometrist refers the insured to an independent ophthalmologist for treatment or a surgical procedure.

83. Upon information and belief, this results in almost all small employer Sanford True Plan insureds being treated by Sanford ophthalmologists, regardless of whether the optometrist initially referred the insured to Plaintiff Ophthalmology Ltd. or another independent ophthalmology provider.

84. The South Dakota service area for the small employer Sanford True Plan consists of Brown, Lincoln, and Minnehaha counties.

85. The service area for the small employer Sanford True plan also includes approved counties in Minnesota, North Dakota, and Iowa.

86. Plaintiff OI is willing and fully qualified to meet the terms and conditions SHP has with the Sanford orthopedists so as to participate on the panel of providers in the small employer Sanford True Plan.

87. Plaintiff SFSH is willing and fully qualified to meet the terms and conditions SHP has with Sanford's hospitals, including Sanford USD Medical Center, so as to participate on the panel of providers in the small employer Sanford True Plan.

88. Plaintiff SFSH d/b/a Sioux Falls Urgent Care is willing and fully qualified to meet the terms and conditions SHP has with Sanford Acute Care so as to participate on the panel of providers in the small employer Sanford True Plan.

89. Plaintiff SFSH d/b/a Workforce is willing and fully qualified to meet the terms and conditions SHP has with Sanford Occupational Medicine Clinic so as to participate on the panel of providers in the small employer Sanford True Plan.

90. Plaintiff SFSH d/b/a Midwest Pain is willing and fully qualified to meet the terms and conditions SHP has with Sanford Physical Medicine and Rehabilitation so as to participate on the panel of providers in the small employer Sanford True Plan.

91. Plaintiff SFSH d/b/a Midwest Imaging is willing and fully qualified to meet the terms and conditions SHP has with Sanford Clinic Radiology so as to participate on the panel of providers in the small employer Sanford True Plan.

92. Plaintiff Ophthalmology Ltd. is willing and fully qualified to meet the terms and conditions SHP has with Sanford Eye Center and Optical so as to participate on the panel of providers in the small employer Sanford True Plan.

93. Plaintiff Eye Surgery Center is willing and fully qualified to meet the terms and conditions SHP has with its eye surgery facilities, including Sanford USD Medical Center, so as to participate on the panel of providers in the small employer Sanford True Plan.

INDIVIDUAL PLANS

94. SHP offers three health insurance plans to individuals on and off the Health Insurance Marketplace/Health Care Exchange: the Sanford Safeguard, Sanford Simplicity, and Sanford True Plans.

95. The Sanford Safeguard Plan is short term, limited duration medical insurance for individuals that need to fill gaps in medical insurance coverage.

96. The Sanford Safeguard Plan is intended to be temporary and provide less than 12 months of coverage.

97. The Sanford Safeguard Plan is a broad plan.

98. The Plaintiffs are participating providers in the Sanford Safeguard Plan.

99. Like the large and small employer Sanford Simplicity Plans, the individual Sanford Simplicity Plan is a broad plan that allows insureds to choose their own providers, including specialists, without a referral.

100. The Plaintiffs are participating providers in the individual Sanford Simplicity Plan.

SANFORD TRUE PLAN—INDIVIDUALS

101. SHP offers the Sanford True Plan to individuals.

102. SHP, through its agents, brokers, and representatives, markets the Sanford True Plan to individuals and represents that the Sanford True Plan saves approximately 20% in premium savings compared to the Sanford Simplicity Plan for individuals.

103. The only non-chiropractic, orthopedic-related health care providers allowed to participate on the individual Sanford True Plan's panel of orthopedic providers are Sanford Health providers, including Sanford Orthopedics and Sports Medicine, Sanford Physical Medicine and Rehabilitation, and Sanford Health Midtown Clinic.

104. The only hospitals allowed to participate on the individual Sanford True Plan's panel of hospital and facilities providers are Sanford Health hospitals and facilities, including Sanford USD Medical Center.

105. The only urgent care providers allowed to participate on the individual Sanford True Plan's panel of urgent care providers are Sanford Health providers, including Sanford Health Acute Care.

106. The only occupational medicine providers allowed to participate on the individual Sanford True Plan's occupational medicine panel of providers are Sanford Health providers, including Sanford Occupational Medicine Clinic.

107. The only pain management providers allowed to participate on the individual Sanford True Plan's pain management panel of providers are Sanford Health providers, including Sanford Physical Medicine and Rehabilitation.

108. The only imaging providers allowed to participate on the individual Sanford True Plan's imaging panel providers are Sanford Health providers, including Sanford Clinic Radiology.

109. The only ophthalmologists allowed to participate in the individual Sanford True Plan are Sanford Health Providers, including Sanford Eye Center and Optical.

110. SHP does not allow Plaintiff Ophthalmology Ltd.'s optometrists to participate in the individual Sanford True Plan.

111. SHP does, however, allow a number of independent optometrists in the Sioux Falls metro area to participate in the individual Sanford True Plan.

112. Upon information and belief, SHP does so because their insureds are forced to pay 100% out of pocket if an optometrist refers the insured to an independent ophthalmologist for treatment or a surgical procedure.

113. Upon information and belief, this results in almost all individual Sanford True Plan insureds being treated by Sanford ophthalmologists, regardless of whether the optometrist initially referred the insured to Plaintiff Ophthalmology Ltd. or another independent ophthalmology provider.

114. Plaintiff OI is willing and fully qualified to meet the terms and conditions SHP has with the Sanford orthopedists for participation on the individual Sanford True Plan's panel of providers.

115. Plaintiff SFSH is willing and fully qualified to meet the terms and conditions SHP has with Sanford's hospitals, including Sanford USD Medical Center, so as to participate on the individual Sanford True Plan's panel of providers.

116. Plaintiff SFSH d/b/a Sioux Falls Urgent Care is willing and fully qualified to meet the terms and conditions SHP has with Sanford Acute Care so as to participate on the individual Sanford True Plan's panel of providers.

117. Plaintiff SFSH d/b/a Workforce is willing and fully qualified to meet the terms and conditions SHP has with Sanford Occupational Medicine Clinic so as to participate on the individual Sanford True Plan's panel of providers.

118. Plaintiff SFSH d/b/a Midwest Pain is willing and fully qualified to meet the terms and conditions SHP has with Sanford Physical Medicine and Rehabilitation so as to participate on the individual Sanford True Plan's panel of providers.

119. Plaintiff SFSH d/b/a Midwest Imaging is willing and fully qualified to meet the terms and conditions SHP has with Sanford Clinic Radiology so as to participate on the individual Sanford True Plan's panel of providers.

120. Plaintiff Ophthalmology Ltd. is willing and fully qualified to meet the terms and conditions SHP has with Sanford Eye Center and Optical so as to participate on the panel of providers in the individual Sanford True Plan.

121. Plaintiff Eye Surgery Center is willing and fully qualified to meet the terms and conditions SHP has with its eye surgery facilities, including Sanford USD Medical Center, so as to participate on the panel of providers in the individual Sanford True Plan.

SDCL § 58-17J-2—SOUTH DAKOTA'S ANY WILLING PROVIDER LAW

122. The South Dakota Supreme Court has recognized that legislation that targets health maintenance organizations, preferred provider organizations, and individual practice associations is a valid exercise of the state's police power because of the "great potential" for such organizations to funnel patients away from classes of medical providers. *South Dakota Physician's Health Group v. State of South Dakota By and Through its Department of Health*, 447 N.W.2d 511, 515 (S.D. 1989).

123. The Court struck down a statute as unconstitutional where the title of the statute purported to promote non-discrimination amongst medical providers, but the text allowed government health insurance contracts with health maintenance organizations, preferred provider organizations, and individual practice associations to discriminate against any provider that was not a physician, optometrist or chiropractor. *Id.* at 512-514.

124. The South Dakota Legislature has, for quite some time, prohibited self-insured health insurance plans for government employees from reimbursing medical providers in a manner that discriminates against certain classes of medical providers. SDCL § 58-17-54.

125. For over thirty years, South Dakota has had an Any Willing Pharmacy law that requires health insurers to allow pharmacies to participate in the health insurer's plan upon the same terms and conditions offered to pharmacies participating in the plan. SDCL § 58-18-37.

126. Although they can vary from state to state, AWP laws typically require "health care insurers to admit qualified health care providers into the insurer's provider networks if they are willing to meet the terms and conditions of participation." *Prudential Ins. Co. of America v. National Park Medical Center, Inc.*, 413 F.3d 897, 902 (8th Cir. 2005) (analyzing the state of Arkansas' AWP law in the context of a preemption claim).

127. The United States Supreme Court unanimously upheld the State of Kentucky's AWP law as a valid exercise of the state's power to regulate the business of insurance under the McCarran-Ferguson Act. *Kentucky Ass'n of Health Plans v. Miller*, 538 U.S. 329, 331-339 (2003) (holding Kentucky's AWP law was not preempted by the Employee Retirement Income Security Act).

128. South Dakota's AWP law was passed by the voters as an Initiated Measure 17 (IM 17) with over 60% of the vote.

129. IM 17 became effective November 13, 2014, as SDCL § 58-17J-2.

130. South Dakota's AWP law provides:

> No health insurer, including the South Dakota Medicaid program may obstruct patient choice by excluding a health care provider licensed under the laws of this state from participating on the health insurer's panel of providers if the

> provider is located within the geographic coverage area of the health benefit plan and is willing and fully qualified to meet the terms and conditions of participation as established by the health insurer.

Id.

131. As of 2020, over 70% of the market share for health insurance in South Dakota was held by only three entities: Wellmark of South Dakota, Inc., Avera Health Plans, Inc., and Sanford Health Plan, Inc.

132. As of 2020, SHP has earned over 250 million dollars in premiums.

133. As of 2020, SHP has approximately 212 million dollars in losses.

134. Upon information and belief, a significant amount of the "losses" reported by SHP are for claims paid to its affiliates, including Sanford Health and Sanford Clinic.

THE 2015 LAWSUIT (CIV. 15-899)

135. Plaintiff SFSH brought an action against SHP in 2015 to enforce South Dakota's AWP law.

136. The Court ordered SHP to negotiate with Plaintiff SFSH, but declined to address the issue of whether closed plans were permissible pursuant to SDCL § 58-17J-2. A copy of the Court's Order on Motion to Enforce is attached hereto as Exhibit 1.

137. The Court did not rule on whether PPO plans or tiered plans were permissible.

138. Upon information and belief, SHP did not have a tiered plan at the time of the 2015 lawsuit.

FIRST CAUSE OF ACTION
DECLARATORY JUDGMENT—TIER 1 OF THE SANFORD PLUS PLAN

139. Paragraphs 1 through 138 are incorporated herein as if set forth in full.

140. Plaintiffs and Defendant SHP's rights, status, and legal relations are affected by SDCL § 58-17J-1 and SDCL § 58-17J-2.

141. A controversy exists between Plaintiffs and Defendant SHP with respect to the interpretation of SDCL § 58-17J-1 and SDCL § 58-17J-2.

142. Specifically, Defendant SHP will not allow Plaintiffs to participate in tier 1 of the Sanford Plus Plan's panel of providers and SHP does not believe SDCL § 58-17J-1 and SDCL § 58-17-J-2 require it to do so.

143. A declaratory judgment from this Court will remove any uncertainty and terminate the controversy between the parties.

144. Pursuant to South Dakota's Uniform Declaratory Judgment Act, the Plaintiffs request a declaration from this Court that (1) Plaintiffs are located within the geographic coverage of the Sanford Plus Plan, (2) that the Plaintiffs are willing and fully qualified to meet the terms and conditions of participating in tier 1 of the Sanford Plus Plan's panel of providers as established by SHP in its existing agreements with the Sanford providers, and, as a result, (3) SHP must allow the Plaintiffs to participate in tier 1 of the Sanford Plus Plan's panel of providers.

SECOND CAUSE OF ACTION
DECLARATORY JUDGMENT—PARTICIPATION IN ALL OF SANFORD'S TRUE PLANS

145. Paragraphs 1 through 144 are incorporated herein as if set forth in full.

146. Plaintiffs and Defendant SHP's rights, status, and legal relations are affected by SDCL § 58-17J-1 and SDCL § 58-17J-2.

147. A controversy exists between Plaintiffs and Defendant SHP with respect to the interpretation of SDCL § 58-17J-1 and SDCL § 58-17J-2.

148. Specifically, Defendant SHP will not allow Plaintiffs to participate on the large employer, small employer, or individual Sanford True Plan's panel of providers and Defendant SHP does not believe SDCL § 58-17J-1 and SDCL § 58-17-J-2 require it to do so.

149. A declaratory judgment from this Court will remove any uncertainty and terminate the controversy between the parties.

150. Pursuant to South Dakota's Uniform Declaratory Judgment Act, the Plaintiffs request a declaration from this Court that (1) Plaintiffs are located within the geographic coverage of the large employer, small employer, and individual Sanford True Plans, (2) that the Plaintiffs are willing and fully qualified to meet the terms and conditions of participating in the large employer, small employer, and individual Sanford True Plan's panel of providers as established by SHP in its existing agreements with the Sanford providers, and, as a result, (3) SHP must allow the Plaintiffs to participate in the large employer, small employer, and individual Sanford True Plan's panel of providers.

THIRD CAUSE OF ACTION
DECLARATORY JUDGMENT—REPEAL BY IMPLICATION

151. Paragraphs 1 through 150 are incorporated herein as if set forth in full.

152. Plaintiffs and Defendant SHP's rights, status, and legal relations are affected by SDCL § 58-17J-1 and SDCL § 58-17J-2.

153. To the extent statutes enacted prior to SDCL § 58-17J-1 and SDCL § 58-17J-2 cannot be harmonized with the latter statutes, a controversy exists between the parties as to whether the conflicting statutes that pre-date SDCL § 58-17J-1 and SDCL § 58-17J-2 have been repealed by implication.

154. To the extent statutes that pre-date SDCL § 58-17J-1 and SDCL § 58-17J-2 cannot be harmonized with the latter statutes, the Plaintiffs request a declaration that SDCL § 58-17J-1 and SDCL § 58-17J-2 repeal by implication the prior and conflicting statutes, including but not limited to any prior enacted legislation permitting a health insurer to terminate participating providers without cause.

Wherefore, the Plaintiffs respectfully pray for the following relief:

(1) For declaratory judgments outlined above, which will enable the Plaintiffs to participate as tier 1 providers on the Sanford Plus Plan's panel of providers and participate on the panel of providers in the large employer, small employer, and individual Sanford True Plans;

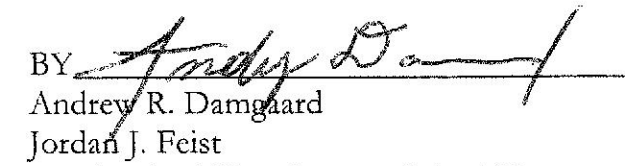
(2) A declaratory judgment, if necessary, declaring that SDCL § 58-17J-1 and SDCL § 58-17J-2 repeal by implication any conflicting statutes that were enacted prior to SDCL § 58-17J-1 and SDCL § 58-17J-2; and

(3) For an award of costs pursuant to SDCL § 21-24-11;

(4) For such additional relief the Court determines just.

Dated this 29th day of September, 2021.

WOODS, FULLER, SHULTZ & SMITH, PC

BY 

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Sioux Falls, SD 57117-5027
(605) 338-4304
Attorneys for the Plaintiffs

STATE OF SOUTH DAKOTA) : SS COUNTY OF MINNEHAHA)	IN CIRCUIT COURT SECOND JUDICIAL CIRCUIT
SIOUX FALLS SPECIALTY HOSPITAL, L.L.P., Plaintiff, vs. SANFORD HEALTH PLAN, Defendant.	CIV. 15-899 **ORDER ON MOTION TO ENFORCE**

On August 22, 2016, a hearing was held on Sioux Falls Specialty Hospital, L.L.P.'s Motion to Enforce before the Honorable Larry E. Long. Woods, Fuller, Shultz & Smith, P.C. and James A. Power, Melanie L. Carpenter, and James E. Moore appeared on behalf of Sioux Falls Specialty Hospital, L.L.P. Evans, Haigh & Hinton, L.L.P. and Melissa C. Hinton appeared on behalf of Sanford Health Plan. After considering the files and records herein, including the parties' briefs and the arguments of counsel, IT IS HEREBY ORDERED as follows:

1. The Motion to Enforce is denied as moot with respect to Sioux Falls Specialty Hospital, L.L.P.'s request that the Court order Sanford Health Plan to remove Paragraph 2(a) from the proposed Contract, in light of Sanford Health Plan's offer to remove that provision voluntarily;

2. The Motion to Enforce is denied with respect to Sioux Falls Specialty Hospital, L.L.P.'s request that the Court strike the last two sentences of Paragraph 22(b) from the proposed Contract because the parties agreed during the hearing that those sentences should not apply to currently pending Circuit Court and DOI proceedings;

3. The Court declines to address the issue of whether closed networks/plans are permissible pursuant to SDCL § 58-17J-2;

4. The Court declines to address whether SHP must grant SFSH access to its closed networks/plans pursuant to SDCL § 58-17J-2; and

5. Upon execution and filing of this Order on Motion to Enforce, this proceeding (Civ. 15-899) is concluded and the Clerk make take any necessary steps to close the Court's file.

Dated this 6th day of Feb., 2017.

BY THE COURT:

Honorable Larry E. Long
Circuit Court Judge

ATTEST:
ANGELA M. GRIES, CLERK

By: _____
Deputy Clerk

(SEAL)

FILED
FEB 06 2017
Minnehaha County, S.D.
Clerk Circuit Court

Provider Network Descriptions:

Broad Network
Consists of over 25,000 providers within the Dakotas, Minnesota and Iowa. The network expands beyond the Sanford Health care system, including access to Multiplan's nationwide networks for urgent and emergent coverage while traveling or for members residing outside the Sanford Health Plan service area.

To receive the highest level of benefits, you will need to see providers listed in this directory. For more information about benefits, contact Customer Service.

Tiered Network
Sanford Health Plan's Broad network is grouped into two tiers. Member's cost share is based on the tier of the provider from whom they receive care. Tier 1 (lowest member cost-share) includes our large care system of Sanford Health providers and facilities. Tier 2 (higher member cost-share) includes the broad network that expands beyond the Sanford Health system, including access to Multiplan's nationwide networks for urgent and emergent coverage while traveling or for members residing outside the Sanford Health Plan service area.

To receive the highest level of benefits, you will need to see providers listed in this directory. For more information about benefits, contact Customer Service.

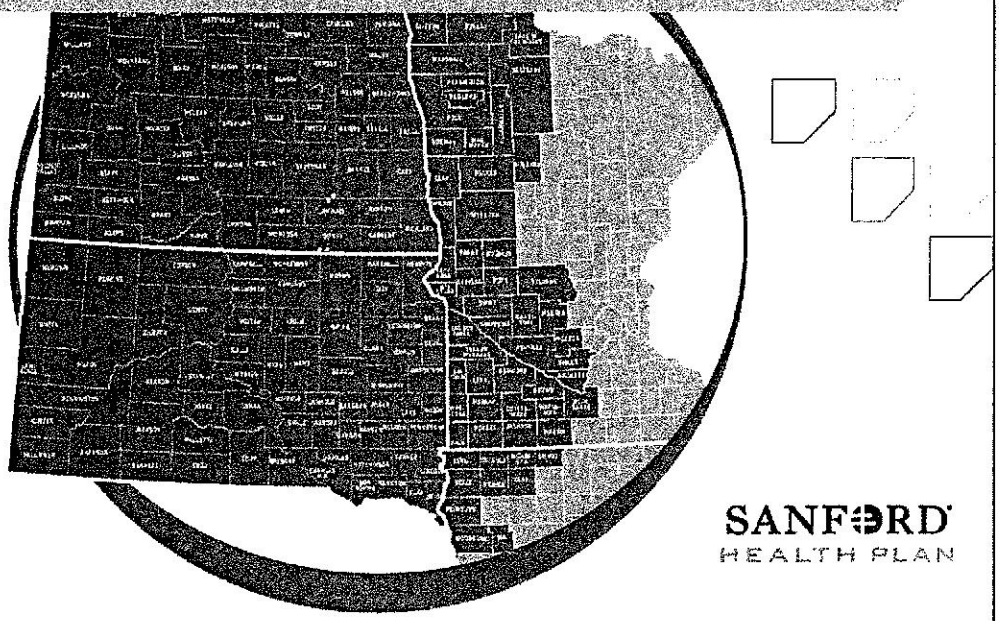
Focused Network
Consists of providers in our large care system of Sanford Health providers and facilities, plus some additional independent providers across the Dakotas, Minnesota and Iowa.

To receive benefits, you will need to see providers listed in the Focused Network directory. For more information about benefits, contact Customer Service.

Appellees' Appendix 065
EXHIBIT 8

SANFORD PLUS LARGE EMPLOYER

NORTH DAKOTA, SOUTH DAKOTA, MINNESOTA AND IOWA



SANFORD
HEALTH PLAN

Plan Profile: Our Sanford PLUS plans are offered to large employers with 51 or more total employees. Eligible employees must reside within approved zip codes to enroll in this plan. Sanford PLUS plans must always be packaged with similar side-by-side Signature Series plans to provide choices to employees customized to fit their insurance needs.

Provider Network: Consists of our broad and focused provider network. Tier 1 (lowest member cost-share) includes our large care system of Sanford Health providers and facilities, plus some additional independent providers across the Dakotas, Minnesota and Iowa, while Tier 2 (higher member cost-share) includes the broad network that expands beyond the Sanford Health care system, including access to a nationwide network while traveling or for employees residing outside the Sanford Health Plan service area. You can choose to see any licensed provider for covered services without a referral, whether the provider is in-network or out-of-network. Claims will pay according to the appropriate level of benefits.

- **Over 375,000** plan options
- HRA, HSA, FSA Services
- Tiered Network
- Video visit and e-visit services offered at a **$0 copay** with Sanford Health providers. Exclusions apply.
- Additional Lab & X-Ray Rider can be purchased
- **Fitness Center Reimbursement** and Wellness Services
- Access to a **nationwide network**
- COBRA Administration offered **at no additional cost**
- Up to **13% in premium savings** compared to Signature Series plans

Sales Fact Sheet

Plan Name: **SANFORD PLUS** Provider Network: **TIERED**

Service Area
The Sanford service area consists of South Dakota, North Dakota and approved counties of Minnesota and Iowa.

Large Group Sanford PLUS Business Rules

- If an employer offers Sanford PLUS (tiered network), they are required to offer Signature Series (broad network) plan as a side-by-side. The Signature Series plans must mirror the Tier 1 cost sharing on Sanford PLUS.
- Employers cannot offer TRUE Plan side-by-side with a Sanford PLUS Plan

Sanford PLUS Eligibility Rules:

Employer Eligibility Rules:

a. Business must be domiciled in counties where SHP is licensed (all counties of SD, ND and approved counties of Minnesota and Iowa.)
b. Groups must submit census to include gender, age, and each employee's zip code.
c. South Dakota: 30% of eligible employees must reside in the Sanford-PLUS approved zip codes.
d. North Dakota, Minnesota & Iowa: 50% of eligible employees must reside in the Sanford-PLUS approved zip codes.
e. Large Groups (51+): Only permitted to offer 2 Signature Series plans, and 2 Sanford TRUE plans or 2 Sanford PLUS plans, to a maximum of 4 plan options, no more.

Employee Eligibility Rules: Eligible employees reside in Sanford PLUS approved zip codes.

Other Business Rules:

1. Subscribers who cover Spouses and/or Dependents who permanently reside out of the Sanford PLUS service area, are NOT eligible for the Sanford PLUS plan (i.e. court ordered spousal/ dependent coverage).
2. Subscribers who cover college students who attend school out of the Sanford PLUS service area are eligible for the Sanford PLUS Plan, however, must acknowledge that most providers are at Tier 2 level.
3. Sanford PLUS products include MPI and PCHS and wrap network logos on ID cards.
4. MPI PHCS network providers are in Tier 2 for all services (elective, urgent and emergent care services).
5. Members must notify SHP of their move out of the Sanford PLUS service area within 30 days.
   a. Member will automatically be moved to the equivalent Signature Series (Broad Network) Plan.
   b. Member cannot switch deductible level plans.
   c. Accumulators will roll-over for group members
   d. Members will receive a new ID card with new Group ID and marketing brand scheme/color

6. Prior-Authorizations:
   a. The presence of an authorization for out-of-network providers will apply to Tier 2.
   b. Absence of a referral, when required, results in the claim being processed against the next lowest tier.
   c. If a claim is appealed for reconsideration and approved, the claim will process according to the network level of the provider (unless emergency or access/ availability factor in).
      Use of Tier 1=Tier 1 cost share
      Use of Tier 2=Tier 2 cost share
      Use of OON=OON.

Sanford-PLUS Plan Design

Coverage Level	In-Network/Tier 1	In-Network/Tier 2	Out-Of-Network
Provider Network	**FOCUSED**	**BROAD**	**OUT-OF-NETWORK**
Deductible	$xxxx (see options grid)	2x the Tier 1 deductible amount	3x the Tier 1 deductible amount
Coinsurance	90%/10% or 80%/20%	20% more than Tier 1 coinsurance	10% more than Tier 2 coinsurance – not to fall below 50% coinsurance.
MOOP	See options grid	See options grid	3x the Tier 1 MOOP
Office Visits	$xx copay (see options grid)	$20 more copay than Tier 1 copay amount	Ded/Coinsurance

PLUS Product Review

Tier 1 vs. Tier 2

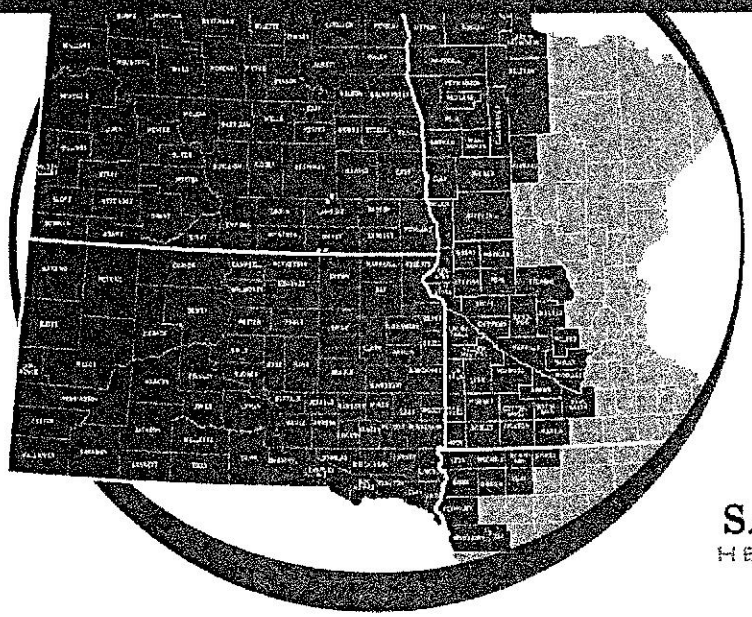
- Tier 1
  - Sanford on the door -those who are managed, leased and owned by Sanford
  - Richest benefit
  - Only applies to Tier 1 providers and Urgent/Emrgent Care
- Tier 2
  - Patriating Providers
  - Still considered "In-Network", but less rich benefits
  - Cannot be PA'd into – not even for access and availability

Other Business Rules:

1. Subscribers who cover others who permanently reside out of the PLUS service area, are NOT eligible
   - Subscribers who cover college students who attend school out of the Sanford-PLUS service area ARE eligible for the Sanford-Plus Plan, however, must acknowledge that most providers are at Tier 2 level.
2. Sanford-PLUS products include MPI and PCHS and wrap network logos on ID cards. No Preferred One or TLC.
   - MPI-PHCS network providers are in Tier 2 for all services (elective, urgent and emergent care services).
3. Members must notify SHP of their move out of the Sanford-PLUS service area within 30 days.
   - Member will automatically be moved to the equivalent Signature Series Open Access Plan.
   - Member cannot switch deductible level plans.
   - Accumulators will roll-over for group members

Sanford TRUE Large Employer

NORTH DAKOTA, SOUTH DAKOTA, MINNESOTA AND IOWA



SANFORD
HEALTH PLAN

Plan Profile: Our Sanford TRUE plans are offered to large employers with 51 or more total employees. Eligible employees must reside within approved zip codes to enroll in this plan. Sanford TRUE plans must always be packaged with side-by-side Signature Series plans to provide choices to employees customized to fit their insurance needs.

Provider Network: Consists of 2,200 providers, including access to our large care system of Sanford Health providers and facilities, plus some additional independent providers across the Dakotas, Minnesota and Iowa. You can choose to see any licensed Sanford Health provider for covered services without a referral for in-network coverage. This plan does not have out-of-network coverage, except for urgent and emergent situations.

- **1.8 million** plan options
- HRA, HSA, FSA Services
- Focused Network
- Video visit and e-visit services offered at a **$0 copay** with Sanford Health providers. Exclusions apply.
- Additional Lab & X-Ray Rider can be purchased
- **Fitness Center Reimbursement** and Wellness Services
- COBRA Administration offered **at no additional cost**
- No out-of-network coverage, except urgent and emergent services
- Approximately **20% in premium savings** compared to Signature Series plans

SVHP-2295 Rev. 7/20

Appellees' Appendix 070
EXHIBIT 8

Sales Fact Sheet

Plan Name: **SANFORD TRUE** Provider Network: **FOCUSED**

Service Area
The Sanford service area consists of South Dakota, North Dakota and approved counties of Minnesota and Iowa.

Large Group Sanford TRUE Business Rules

- If an employer offers Sanford TRUE (focused network), they are required to offer Signature Series (broad network) plan as a side-by-side.
- Employers cannot offer TRUE Plan side-by-side with a Sanford PLUS Plan

Sanford TRUE Eligibility Rules:

Employer Eligibility Rules:

a. Business must be located South Dakota, North Dakota or approved counties of Minnesota and Iowa.
b. Groups must submit census to include gender, age, and each employee's zip code.
c. South Dakota: 30% of eligible employees must reside in the TRUE counties or expanded zip codes.
d. North Dakota, Minnesota & Iowa: 50% of eligible employees must reside in the TRUE counties.
e. Large Groups (51+): Only permitted to offer 2 Signature Series plans, and 2 TRUE plans, to a maximum of 4 plan options, no more.

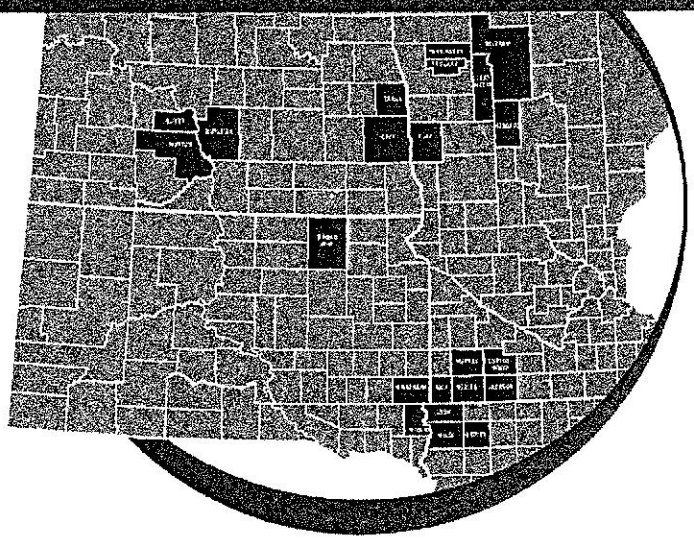
Employee Eligibility Rules: Eligible employees reside in Sanford TRUE approved zip codes.

Other Business Rules:

- Subscribers who cover Spouses and/or Dependents who permanently reside out of the TRUE service area **are not eligible** for the TRUE plan (i.e. court ordered spousal coverage or dependent coverage).
- Subscribers who cover college students who attend school out of the TRUE service area are eligible for the TRUE Plan, and acknowledge that coverage will only be for urgent/emergent care and that all elective services must be received at an in-network provider in the TRUE service area.
- TRUE products include MPI and wrap network logos on ID cards but discounts are ONLY accessed for urgent and emergent care services.
- Members must notify SHP of their move out of the TRUE service area within 30 days.
  a. Member will automatically be moved to the equivalent Signature Series (Broad Network) Plan.
  b. Member cannot switch metal level plans or deductible level plans.
  c. Accumulators will roll-over for group members
  d. Members will receive a new ID card with new Group ID and marketing brand scheme/color

Appellees' Appendix 071
EXHIBIT 8

SANFORD TRUE SMALL EMPLOYER
SOUTH DAKOTA, NORTH DAKOTA, MINNESOTA AND IOWA



SANFORD
HEALTH PLAN

Plan Profile: Sanford TRUE plans are offered to small employers with 50 or less total employees. Eligible employees must reside within approved zip codes to enroll in this plan. Employers with more than five total employees have the capability to choose up to three plan options for their employees, along with the same *Simplicity* plan options.

Provider Network: Consists of 2,200 providers, including access to our large care system of Sanford Health providers and facilities, plus some additional independent providers across the Dakotas, Minnesota and Iowa. You can choose to see any licensed Sanford Health provider for covered services without a referral for in-network coverage. This plan does not have out-of-network coverage, except for urgent and emergent situations.

- **11** plan options
- HRA, HSA, FSA Services
- Focused Network
- Video visit and e-visit services offered at a **$0 copay** with Sanford Health providers. Exclusions apply.
- **Fitness Center Reimbursement** and Wellness Services
- **Pediatric Dental** and **Vision** benefits built into all plan options
- COBRA Administration offered **at no additional cost**
- No out-of-network coverage, except urgent and emergent services
- An **interactive** online enrollment platform
- Approximately **20% in premium savings** compared to *Simplicity* plans

SVHP-1759 Rev. 7/20

Appellees' Appendix 072
EXHIBIT 9

Sales Fact Sheet

Plan Name: **SANFORD TRUE** Provider Network: **FOCUSED**

Service Area

The Sanford service area consists of the following approved counties:

- South Dakota counties: Brown, Lincoln, Minnehaha
- North Dakota counties: Burleigh, Morton, Oliver, Cass, Traill
- Minnesota counties: Beltrami, Clay, Clearwater, Cottonwood, Hubbard, Jackson, Murray, Nobles, Red Lake, Rock, Pennington
- Iowa counties: Lyon, O'Brien, and Sioux.

Small Group Sanford TRUE Business Rules

- If an employer offers Sanford TRUE (focused network), they are required to offer Simplicity (broad network) plan as a side-by-side.
- There are no minimum requirements for employee eligibility to offer these plans side by side in the small group market.

Sanford TRUE Eligibility Rules (Small Group):

Employer Eligibility Rules:

Business must be domiciled in approved counties where SHP is licensed to sell TRUE products.

i. South Dakota: Brown, Minnehaha, Lincoln
ii. North Dakota: Burleigh, Morton, Oliver, Cass, Traill
iii. Minnesota counties: Beltrami, Clay, Clearwater, Cottonwood, Hubbard, Jackson, Murray, Nobles, Red Lake, Rock, Pennington
iiii. Iowa counties: Lyon, O'Brien, and Sioux.

Employee Eligibility Rules: Eligible employees reside in Sanford TRUE approved zip codes.

Other Business Rules:

- Subscribers who cover Spouses and/or Dependents who permanently reside out of the TRUE service area, are not eligible for the TRUE plan (i.e. court ordered spousal coverage or dependent coverage).
- Subscribers who cover college students who attend school out of the TRUE service area are eligible for the TRUE Plan, and acknowledge that coverage will only be for urgent/emergent care and that all elective services must be received at in-network provider in the TRUE service area.
- TRUE products include MPI and wrap network logos on ID cards but discounts are ONLY accessed for urgent and emergent care services.
- Members must notify SHP of their move out of the TRUE service area within 30 days.
  a. Member will automatically be moved to the equivalent *Simplicity* (Broad Network) Plan.
  b. Member cannot switch metal level plans or deductible level plans.
  c. Accumulators will roll-over for group members
  d. Members will receive a new ID card with new Group ID and marketing brand scheme/color

Appellees' Appendix 074
EXHIBIT 9

Getting to know our Sanford TRUE plans

Who can purchase Sanford TRUE small group plans?

Small employers with 50 or less total employees domiciled in approved counties of South Dakota, North Dakota and approved counties of Minnesota and Iowa.
Your eligibility and rates will depend on the state and zip code in which you reside.
South Dakota counties: Brown, Lincoln, Minnehaha
North Dakota counties: Burleigh, Cass, Morton, Oliver, Traill
Minnesota: Beltrami, Clay, Clearwater, Cottonwood, Hubbard, Jackson, Murray, Nobles, Pennington (TRF), Red Lake, Rock
Iowa: Lyon, O'Brien, and Sioux

What are the main differences between *Simplicity* and Sanford TRUE plans?

The Sanford TRUE plans are offered to employers in counties where we have ensured a robust provider network is available. The Focused Network consists of 2,200 providers, including access to our large care system of Sanford Health providers and facilities, plus some additional independent providers across the Dakotas, Minnesota and Iowa. You can choose to see any licensed Sanford Health provider for covered services without a referral for in-network coverage. This plan does not have out-of-network coverage, except for urgent and emergent situations.

The *Simplicity* plans are offered to employers in all counties of South Dakota, North Dakota and specific counties of Iowa and Minnesota. The Broad Network consists of over 25,000 providers within the Dakotas, Minnesota and Iowa. The network expands beyond the Sanford Health care system, including access to a nationwide network while traveling or for employees residing outside the Sanford Health Plan service area. You can choose to see any licensed provider for covered services without a referral, whether the provider is in-network or out-of-network. Claims will pay according to the appropriate level of benefits.

Is there a limit to how many plan options I can offer my employees?

Yes. Sanford Health Plan offers small employers the flexibility to choose up to three of our small group Simplicity plan options side-by-side with our TRUE plans depending on group size. We understand that when it comes to health insurance, one plan doesn't fit all. Your employees deserve a choice and we are here to meet those needs. Only employees who are domiciled in the approved counties or expanded zip codes are eligible for the Sanford TRUE plans.

Where can I find more information about your small group plan options, provider network, rates and other information?

We encourage you to work with your local insurance agent. You can also visit our website at sanfordhealthplan.com or call (605) 333-1089 or toll free at (888) 535-4831.

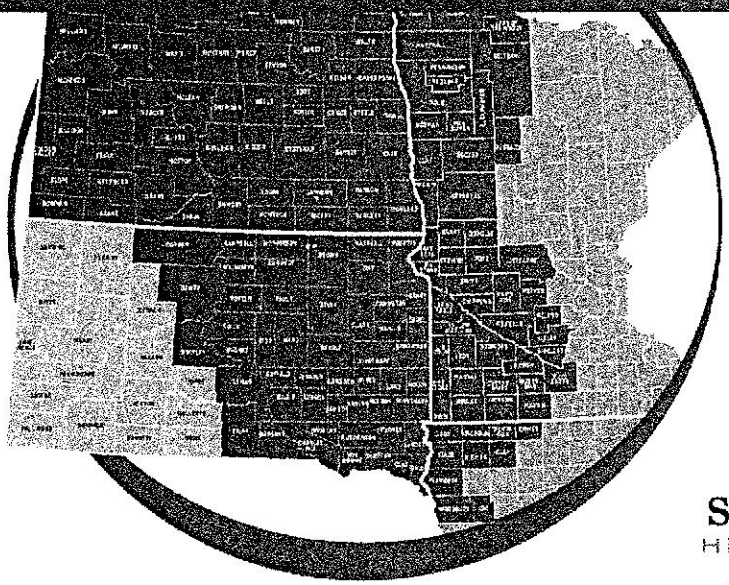
The Sanford TRUE advantage

- Focused Network
- Worldwide emergency coverage, 24-hours a day
- Flexibility to choose your own providers, including specialists, without a referral
- Access to over 60,000 pharmacies nationwide
- Fast, accurate and friendly customer service
- Interactive online enrollment platform
- COBRA Administration provided at no additional cost
- HRA , HSA, FSA Services
- Coverage included for pediatric dental and vision
- Telehealth services (video visits and e-visits)

"The Sanford Health Plan team has been a reliable partner and is ***leading the charge of finding new and innovative ways to deliver services and control costs***. Our employees love having the lower cost option that the TRUE plan offers. Sanford Health Plan offers our employees valuable Wellness and other resources within the Sanford Health system."

— VP Human Resources,
Lifescape, Sioux Falls, SD

SIMPLICITY SMALL EMPLOYER
IOWA, MINNESOTA, NORTH DAKOTA, AND SOUTH DAKOTA



SANFORD
HEALTH PLAN

Plan Profile: Our Simplicity plans are offered to small employers with 50 or less total employees. These are qualified health plans that offer a variety of cost-sharing options. Employers with more than five total employees have the capability to choose up to three plan options for their employees.

Provider Network: Consists of over 25,000 providers within the Dakotas, Minnesota and Iowa. The network expands beyond the Sanford Health care system, including access to a nationwide network while traveling or for employees residing outside the Sanford Health Plan service area. You can choose to see any licensed provider for covered services without a referral, whether the provider is in-network or out-of-network. Claims will pay according to the appropriate level of benefits.

- **11 plan options**
- HRA, HSA, FSA Services
- Broad Network
- Video visit and e-visit services offered at a **$0 copay** with Sanford Health providers. Exclusions apply.
- **Fitness Center Reimbursement** and Wellness Services
- **Pediatric Dental** and **Vision** benefits built into all plan options
- COBRA Administration offered **at no additional cost**
- An **interactive** online enrollment platform
- Access to a **nationwide network**

SVHP-1758 Rev. 7/20

Appellees' Appendix 076
EXHIBIT 9

Sales Fact Sheet

Plan Name: ***SIMPLICITY*** Provider Network: **BROAD**

Service Area
The Sanford service area consists of South Dakota, North Dakota, and approved counties of Iowa and Minnesota (indicated below):

- Iowa: Clay, Dickinson, Emmet, Ida, Lyon, O'Brien, Osceola, Plymouth, Sioux, and Woodbury.
- Minnesota: Becker, Beltrami, Big Stone, Blue Earth, Brown, Chippewa, Clay, Clearwater, Cottonwood, Douglas, Grant, Hubbard, Jackson, Kandiyohi, Kittson, Lac Qui Parle, Lake of the Woods, Lincoln, Lyon, Mahnomen, Marshall, Martin, McLeod, Meeker, Murray, Nicollet, Nobles, Norman, Otter Tail, Pennington, Pipestone, Polk, Pope, Red Lake, Redwood, Renville, Rock, Roseau, Sibley, Stearns, Stevens, Swift, Traverse, Watonwan, Wilkin, and Yellow Medicine.

INDIVIDUAL PLANS

Provider Network Descriptions:

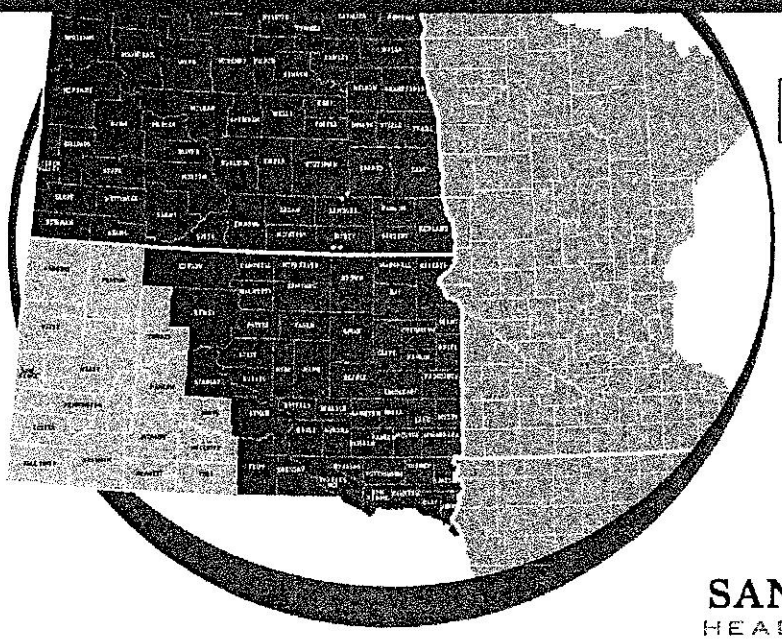
Broad Network
Consists of over 25,000 providers within the Dakotas, Minnesota and Iowa. The network expands beyond the Sanford Health care system, including access to Multiplan's nationwide networks for urgent and emergent coverage while traveling or for members residing outside the Sanford Health Plan service area.

To receive the highest level of benefits, you will need to see providers listed in this directory. For more information about benefits, contact Customer Service.

Focused Network
Consists of providers in our large care system of Sanford Health providers and facilities, plus some additional independent providers across the Dakotas, Minnesota and Iowa.

To receive benefits, you will need to see providers listed in this directory. For more information about benefits, contact Customer Service.

SIMPLICITY INDIVIDUAL
NORTH DAKOTA AND SOUTH DAKOTA



SANFORD
HEALTH PLAN

Plan Profile: *Simplicity* individual plans are offered to individuals in the Dakotas. These plans are a great option for the self-employed, those between jobs, early-retired, families or those no longer eligible for health insurance coverage under their parent's plan. The *Simplicity* plans are qualified health plans that offer a variety of cost-sharing options.

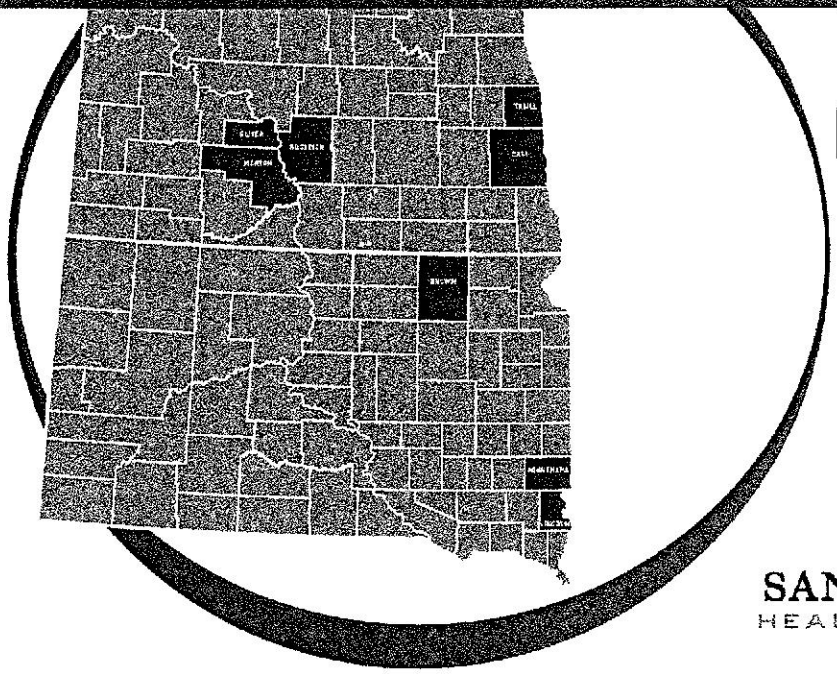
Provider Network: Consists of over 25,000 providers within the Dakotas, Minnesota and Iowa. The network expands beyond the Sanford Health care system, including access to a nationwide network while traveling or for employees residing outside the Sanford Health Plan service area. You can choose to see any licensed provider for covered services without a referral, whether the provider is in-network or out-of-network. Claims will pay according to the appropriate level of benefits.

- **9 plan options** available – also available on the Exchange at healthcare.gov
- Broad Network
- Video visit and e-visit services offered at a **$0 copay** with Sanford Health providers. Exclusions apply.
- **Fitness Center Reimbursement** and Wellness Services
- **Pediatric Dental** and **Vision** benefits built into all plan options
- Access to a **nationwide network**

SVHP-1760 Rev. 7/20

Appellees' Appendix 080
EXHIBIT 10

SANFORD TRUE INDIVIDUAL
NORTH DAKOTA AND SOUTH DAKOTA



SANFORD
HEALTH PLAN

Plan Profile: Sanford TRUE plans are offered to individuals in approved counties of the Dakotas. These plans are a great option for the self-employed, those between jobs, early-retired, families or those no longer eligible for health insurance coverage under their parent's plan. The Sanford TRUE plans are qualified health plans that offer a variety of cost-sharing options.

Provider Network: Consists of 2,200 providers, including access to our large care system of Sanford Health providers and facilities, plus some additional independent providers across the Dakotas, Minnesota and Iowa. You can choose to see any licensed Sanford Health provider for covered services without a referral for in-network coverage. This plan does not have out-of-network coverage, except for urgent and emergent situations.

- **9 plan options** available – also available on the Exchange at healthcare.gov
- Focused Network
- Video visit and e-visit services offered at a **$0 copay** with Sanford Health providers. Exclusions apply.
- **Fitness Center Reimbursement** and Wellness Services
- **Pediatric Dental** and **Vision** benefits built into all plan options
- No out-of-network coverage, except urgent and emergent services
- Approximately **20% in premium savings** compared to *Simplicity* plans

SVHP-1757 Rev. 7/20

Appellees' Appendix 081
EXHIBIT 10

Adding value through network innovation

Through various provider network and plan designs, we provide access to the region's leading health care providers and specialties, while focusing on cost management and health outcomes. Our built-in added value features – virtual care, wellness tools, ancillary service discount programs and more – work to help manage costs for members, while delivering access to affordable, quality services.

Individual Plans	*Simplicity*	Sanford TRUE
Approved Service Area	SD and ND	SD and ND
Provider Network	BROAD	FOCUSED
Nationwide network in all 50 states	✓	
Flexibility to choose your own providers in the network, including specialists, without a referral	✓	✓
Access to over 60,000 pharmacies nationwide	✓	✓
Fast, accurate and friendly customer service	✓	✓
Claims processed locally for greater efficiency	✓	✓
Worldwide emergency coverage 24 hours a day	✓	✓
Online tools: medical information available online at sanfordhealthplan.com/memberlogin	✓	✓
Wellness tools: interactive online health management tool	✓	✓
Virtual care including video visits and e-visits**	✓	✓
Out-of-network benefits available	✓	

*Visit with your agent regarding eligibility rules.
**Video visit and e-visit availability may vary by state.

SANFORD HEALTH PLAN

SVHP-3481 Rev. 9/19

58-17J-1. Definitions.

Terms used in this chapter mean:

(1) "Health benefit plan," any hospital or medical expense policy or certificate, hospital or medical service plan, nonprofit hospital, medical-surgical health service corporation contract or certificate, provider sponsored integrated health delivery network, self-insured plan or plan provided by multiple employer welfare arrangements, health maintenance organization subscriber contract of more than six-month duration, or any health benefit plan that affects the rights of a South Dakota insured and bears a reasonable relation to South Dakota, whether delivered or issued for delivery in South Dakota. The term does not include specified disease, hospital indemnity, fixed indemnity, accident only, credit, dental, vision, Medicare supplement, long-term care or disability income insurance, coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, automobile medical payment insurance, or any plan or coverage exempted from state regulation by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 18;

(2) "Health insurer," any entity within the definitions set forth in subdivisions 58-17F-1(11), (12), and (15), any entity offering a health benefit plan as defined by § 58-17F-2, all self-insurers or multiple employer welfare arrangements, and self-insured employer-organized associations. The term does not include any entity exempted from state regulation by the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 18;

(3) "Health care provider," any individual or entity within the scope of the definition of health care provider as defined by subdivision 58-17F-1(9).

Source: SL 2015, ch 278 (Initiated Measure 17), § 2, eff. Nov. 13, 2014.

IN THE SUPREME COURT
OF THE
STATE OF SOUTH DAKOTA

No. 30207

ORTHOPEDIC INSTITUTE, P.C.; SIOUX FALLS SPECIALTY HOSPITAL, L.L.P.; SIOUX FALLS SPECIALTY HOSPITAL, L.L.P. D/B/A SIOUX FALLS URGENT CARE; SIOUX FALLS SPECIALTY HOSPITAL, L.L.P. D/B/A WORKFORCE OCCUPATIONAL HEALTH AND MEDICAL SERVICES; SIOUX FALLS SPECIALTY HOSPITAL, L.L.P. D/B/A MIDWEST PAIN SPECIALISTS; SIOUX FALLS SPECIALTY HOSPITAL, L.L.P. D/B/A MIDWEST IMAGING; OPHTHALMOLOGY LTD., INC.; and OPHTHALMOLOGY LTD. EYE SURGERY CENTER, L.L.C.,

Plaintiffs and Appellees,

and

SANFORD HEALTH PLAN, INC.,

Defendant and Appellant,

Appeal from the Circuit Court
Second Judicial Circuit
Minnehaha County, South Dakota

The Honorable Rachel R. Rasmussen, Circuit Court Judge

REPLY BRIEF OF APPELLANT SANFORD HEALTH PLAN, INC.

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Delia M. Druley
Evans, Haigh & Arndt, L.L.P.

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Filed: 6/16/2023 4:47 PM CST Supreme Court, State of South Dakota #30207

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Attorneys for Defendant and Appellant Sanford Health Plan, Inc.

Notice of Appeal of Defendant and Appellant Sanford Health Plan, Inc. filed December 29, 2022

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ARGUMENT

The circuit court's decision rewrites the plain language of the AWP Law, creates irreconcilable conflicts with numerous provisions of the Insurance Code that permit closed and tiered plans, and will reduce South Dakotans' freedom to choose their health care providers. Moreover, the summary judgment order relied on argument of counsel that was contradicted by unrebutted record evidence. These errors require reversal.

Plaintiffs' brief does not cure any of these errors. First, Plaintiffs' position rewrites the plain language of the AWP Law, replacing the statutory language of "health insurer" with the language of "health benefit plan." (Resp. 31.)[1] Second, Plaintiffs offer no defense to the unrebutted evidence that the circuit court's decision will *reduce* patients' ability to choose their health care providers—because patients will have fewer affordable providers available. Third, Plaintiffs fail to reconcile their interpretation of the AWP Law with multiple provisions of South Dakota's Insurance Code. Finally, Plaintiffs ignore the undisputed evidentiary record, which contains no evidence about the terms and conditions that would actually be offered to Plaintiffs to join SHP's plans, and which shows that at least one plaintiff would not accept certain terms and conditions.

The circuit court erred in interpreting this important statute and in evaluating the evidentiary record, and should be reversed.

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[1] "Br." refers to SHP's opening brief. "Resp." refers to Plaintiffs' responsive brief. "Avera Br." refers to the brief of Amicus Curiae Avera Health Plans, Inc.

I. South Dakota's AWP Law Does Not Give Providers The Rights Plaintiffs Assert.

Plaintiffs argue that the text and purpose of the AWP Law support their interpretation. But Plaintiffs rely on a decision below that rewrote the statutory text, and that ignored evidence that SHP's interpretation of the AWP Law fulfills its mandate to protect patient choice. (*See* Br. 14-18, 25-28.)

A. The Circuit Court Erred by Replacing the Statute's Plain Language.

"The intent of a statute is determined from what the Legislature said, rather than what the courts think it should have said, and the court must confine itself to the language used." *City of Rapid City v. Estes*, 2011 S.D. 75, ¶ 12, 805 N.W.2d 714, 718. South Dakota's AWP Law provides:

> No health insurer ... may obstruct patient choice by excluding a health care provider licensed under the laws of this state from participating on the *health insurer's panel of providers* if the provider is located within the geographic coverage area of the health benefit plan and is willing and fully qualified to meet the terms and conditions of participation as established by the health insurer.

SDCL 58-17J-2 (emphasis added).

Here, the circuit court replaced the statute's language ("health insurer's panel of providers") with different language ("health benefit plan's panel of providers.") (R. 1273-74.) This changed the AWP Law's meaning without record evidence to support the change. Such re-writing is not permitted. *Peters v. Great W. Bank, Inc.*, 2015 S.D. 4, ¶ 7, 859 N.W.2d 618, 621; *Long v. State*, 2017 S.D. 78, ¶ 13, 904 N.W.2d 358, 364; (*see* Br. 14-18).

Plaintiffs argue that the changed language is justified because the statute also references "the geographic coverage area of the health benefit plan." (Resp. 11-12.) Plaintiffs thus claim that the AWP Law's reference to "panel of providers" is "plan-specific"—i.e., that each health benefit plan must have a separate panel of providers, and that Plaintiffs must be permitted to join every "health benefit plan." Plaintiffs argue that this interpretation must override the AWP Law's plain text, which expressly says that the "panel of providers" belongs to the "health insurer":

> No health insurer ... may obstruct patient choice by excluding a health care provider licensed under the laws of this state from participating on the *health insurer's panel of providers*....

SDCL 58-17J-2 (emphasis added).

The AWP Law is not "plan specific." The statute's drafters knew how to draft a plan-specific law—and they had a model in South Dakota's "Any Willing Pharmacy" law for how to draft such language—but they chose not to do so. (Br. 15-16.) The Pharmacy Law *is* plan specific, and explicitly prohibits insurers from denying any licensed pharmacy or pharmacist the right to participate in "*any policy or plan* on the same terms and conditions as are offered to any other provider of pharmacy services *under the policy or plan*." SDCL 58-18-37(1) (emphasis added). The Pharmacy Law also plainly states that any licensed pharmacy may "elect to participate *in the plan* under the terms and conditions then offered ...." SDCL 58-18-38 (emphasis added).

Despite having this example of how to draft a "plan-specific" law, the drafters of South Dakota's AWP Law did not use language giving providers a right to participate in

every *plan*. Instead, they drafted it to prohibit a health insurer from excluding certain providers from a "health insurer's panel of providers." SDCL 58-17J-2.

Plaintiffs ignore the Pharmacy Law, which the AWP Law drafters chose not to follow when crafting the AWP Law's markedly different language. The drafters' choice of language must be given effect. *See Steinberg v. S. Dakota Dep't of Mil. & Veterans Affs.*, 2000 S.D. 36, ¶ 10, 607 N.W.2d 596, 600 ("Surely if the legislature had wanted to insert the word 'injury' after 'major contributing cause,' it would have done so."); *Stanton v. Hills Materials Co.*, 1996 S.D. 109, ¶¶ 1, 11, 553 N.W.2d 793, 793, 795 (reversing award of attorney fees under statute, holding that had "the legislature intended a different result, it could have said so"); *Bird-Johnson Corp. v. Dana Corp.*, 833 P.2d 375, 377 (Wash. 1992) (difference in language between a voter initiative and legislation on which it was patterned was "clear indication" that the drafters intended the initiative to function differently).[2]

The AWP Law drafters' decision to require a single panel of providers *that belongs to the health insurer* is consistent with the AWP Law's purpose, and only SHP's interpretation fulfills the promise to voters of balancing patient choice with lower costs.

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[2] Plaintiffs now claim—for the first time—that SHP took a contrary position in 2015 before South Dakota's Division of Insurance. This is improper for multiple reasons. First, Plaintiffs cite the 2015 material out of context and without referencing the issues being considered at the time—when Plaintiffs were not yet even on SHP's panel of providers. More importantly, this Court has held "on countless occasions that an issue may not be raised for the first time on appeal." *Long v. State*, 2017 S.D. 79, ¶ 19, 904 N.W.2d 502, 510. Because Plaintiffs never before raised this argument, they have waived it. *State v. Hi Ta Lar*, 2018 S.D. 18, ¶ 17 n.5, 908 N.W.2d 181, 187 n.5.

See SDCL 58-17J-2; (*see also infra*, I.B.; Avera Br. 12-13 (explaining that voters were "Sold a Narrow AWP Law" that would protect patient choice and lower costs)).

Plaintiffs make two more text-based arguments, neither of which is persuasive. First, Plaintiffs note that the phrase "panel of providers" has been used in conjunction with "plans" in two other South Dakota statutes. (Resp. 12-13; *see* R. 1272.) Plaintiffs therefore conclude that the term "panel of providers" must *always* be "plan-specific." (*Id.*) But the opposite is true. In both instances, the South Dakota Legislature expressly qualified the word "panel" with the word "plan." SDCL 58-18A-53(3) (defining "closed panel plan"); SDCL 58-18A-64 (addressing benefits under a "closed panel plan"). Thus, these two statutes use language that is expressly plan-specific—unlike the AWP Law. These statutes, like the Pharmacy Law, show that when drafters of South Dakota laws wanted to make a panel of providers plan-specific, they did so explicitly. With the AWP Law, the drafters knew how to compose plan-specific language, but they chose not to do so. Therefore, the AWP Law must be interpreted differently. *See Steinberg*, 2000 S.D. 36, ¶ 10, 607 N.W.2d 596, 600; *Stanton*, 1996 S.D. 109, ¶ 11, 553 N.W.2d at 795; *Bird-Johnson*, 833 P.2d at 377.

Finally, Plaintiffs argue that the Court must draw conclusions from the fact that a committee of the Legislature failed to pass a bill that SHP supported in 2016, which would have clarified the AWP Law. (Resp. 16-18.) This Court has consistently held that such conclusions are improper. *See Farm Bureau Life Ins. Co. v. Dolly*, 2018 S.D. 28, ¶ 12, 910 N.W.2d 196, 201 ("There are 105 legislators and there may be 105 different, individual reasons they vote for or against a bill."); *Benson v. State*, 2006 S.D. 8, ¶ 72

n.15, 710 N.W.2d 131, 158–59 n.15. Plaintiffs' suggestion that a committee vote on a bill seeking to clarify a law passed by voters years earlier reveals the voters' intent in adopting IM-17 has no legal or factual support.

B. A Plan-Specific Interpretation Thwarts the Purpose of the AWP Law.

Plaintiffs argue that following the AWP Law's language—which provides that the panel of providers belongs to the "health insurer"—would defeat the law's purpose: patient choice of provider. (Resp. 13-14.) Plaintiffs are incorrect. In fact, *Plaintiffs'* interpretation undermines the AWP Law's purpose.

Plaintiffs do not dispute that the AWP Law's purpose is to prevent obstruction of patient choice in health care providers, and to help control health care costs for patients. (*See* Resp. 16; R. 1270.) They suggest, however, that such choice will be obstructed if providers are not in-network for every health insurance plan. (Resp. 14.) This argument is circular, and is not based in the text or purpose of the AWP Law. The statute provides that SHP may not "obstruct patient choice by excluding a health care provider…from participating on the health insurer's panel of providers" if the provider meets the statute's terms and conditions. SDCL 58-17J-2. It is undisputed that every Plaintiff is on SHP's panel of providers. (R. 530 (¶ 11).) Plaintiffs also do not dispute that any SHP patient has the choice to treat with *any one of the Plaintiffs*—and to select a plan that would cover that treatment. (R. 518 (¶ 48); R. 988, 1005, 1064.)[3] SHP thus does not obstruct patients' ability to choose to be treated by any of the Plaintiffs.

[3] Even under Plaintiffs' interpretation, patients must first choose an insurance plan that provides benefits for treating with a particular doctor before their care with that doctor

In contrast, unrebutted evidence shows that Plaintiffs' interpretation of the AWP Law would impair patients' ability to choose providers. The record shows that under Plaintiffs' interpretation—which would force insurers to enter plan contracts with every provider that wants to do so—focused plans would likely be eliminated. (Br. 26-27; *see* R. 519 (¶ 49); 529-30, 532, 1214.) With the elimination of those plans, South Dakota patients would lose the ability to treat with physicians who cost them less and to have that treatment covered by insurance—and would instead be funneled into more expensive insurance plans, or may have to forego health insurance altogether and lose almost any ability to choose a doctor. (*See* R. 519 (admission that eliminating narrow networks means "eliminating a choice of the consumer to choose a lower cost option for [patient] needs"), 529-30, 532, 630.) This frustrates the AWP Law's purpose.

The circuit court did not address this unrebutted evidence, dismissing issues of affordability of coverage as "collateral matters" outside the purpose of the statute. (R. 1270-71, 1273.) But a balance of affordability and greater access to providers is the very purpose of the AWP Law, and is exactly what South Dakota voters were promised. (Avera Br. 12-13.) Moreover, which doctor a patient chooses is tied to the health insurance the patient has. (*See* R. 642.) The AWP Law recognizes this, by expressly tying its goal of "patient choice" to health insurers—and by requiring that providers may participate in a "*health insurer's* panel of providers." SDCL 58-17J-2 (emphasis added); (*see* Br. 27-28 & n.5.).

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will be covered. Thus, Plaintiffs are incorrect to characterize the difference between the parties' positions as a choice of plan versus provider. (Resp. 16, 28 n.18; Br. 28 n.5.)

The difference between the parties' positions is that while SHP's position allows patients to choose their physicians while also having more affordable insurance options, Plaintiffs' interpretation—adopted by the circuit court—will remove lower cost plan options and obstruct choice of health care providers for South Dakotans.

C. The Other States' Any Willing Provider Laws Are Not Instructive.

Because the language and purpose of South Dakota's AWP Law does not support their arguments, Plaintiffs spend many pages relying on laws from other states. (Resp. 8-10, 13.) This discussion sheds no light on this case because: (a) the other states' laws have different language than South Dakota's AWP Law and vest rights in providers—unlike South Dakota's law, which focuses on patients; (b) Plaintiffs misrepresent the U.S. Supreme Court's holding in a key Kentucky case; and (c) Plaintiffs ignore the holdings in the other state cases, relying on dicta that do not apply here.

First, the other states' laws are materially different from South Dakota's AWP Law. Unlike South Dakota's law, which seeks to protect patient choice, most of the other states' laws are expressly intended to protect providers. (*See* Avera Br. 11.) Kentucky's law, for example, states that insurers must "not discriminate against any provider who meets certain conditions." Ky. Rev. Stat. Ann. § 304.17A-270 (West). South Dakota's AWP Law has no such language. With the exception of Arkansas, none of the foreign laws on which Plaintiffs rely are premised on "patient choice." And Arkansas' statute, like South Dakota, allows for closed plans. *Compare* Ark. Code Ann. § 23-99-204(b), *with* Ky. Rev. Stat. Ann. § 304.17A-270 (West), *and* Idaho Code Ann. § 41-3927, *and* Vt. Stat. Ann. tit. 8, § 4089j; *and* Tex. Ins. Code Ann. art. 21.52B; *and* Mass. Gen. Laws

Ann. ch. 176D, § 3B.[4] And with one exception, none of these states' AWP laws refers to a "panel of providers" like South Dakota's law.[5] Therefore, these foreign statutes are not instructive. *See City of Rapid City*, 2011 S.D. 75, ¶ 12, 805 N.W.2d 714, 718 ("The purpose of statutory construction is to discover the true intention of the law, which is to be ascertained primarily from the language expressed in the statute."); *Holscher v. Valley Queen Cheese Factory*, 2006 S.D. 35, ¶ 35, 713 N.W.2d 555, 565 (where meaning of the statute is clear, the Court does "not need to resort to case law, much less case law from another jurisdiction, in order to ascertain its meaning").

Second, Plaintiffs' case citations do not support their interpretation. Plaintiffs lead by misrepresenting the United States Supreme Court's opinion in *Kentucky Ass'n of Health Plans Inc. v. Miller*, 538 U.S. 329 (2003). (Resp. 8.) Contrary to Plaintiffs' assertion, the Supreme Court did not recognize that any willing provider statutes *in general* "impair [insurers'] ability to limit the number of providers with access to their networks." (*Id.* (quoting *Miller*, 538 U.S. at 332).) Rather, the Supreme Court stated only that the specific language of *Kentucky's* law did so. *Miller*, 538 U.S. at 332 ("*Kentucky's AWP statutes* impair petitioners' ability to limit the number of providers...." (emphasis

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[4] Arkansas has the only statute that is premised on patient choice, which provides for a "gatekeeper system" that preserves closed plans. *See* Ark. Code Ann. § 23-99-204(b). The Eighth Circuit case that Plaintiffs cite held that part of the statute was preempted by ERISA because it would eliminate this patient-choice protection. *Prudential Ins. Co. of Am. v. Nat'l Park Med. Ctr., Inc.*, 413 F.3d 897, 914 (8th Cir. 2005).

[5] The exception is North Dakota, which enacted an AWP law while the briefing in this appeal was ongoing.

added)). The Supreme Court did not describe the purpose or function of all AWP laws, much less South Dakota's AWP Law.

Third, the other cases cited by Plaintiffs are not applicable; the quoted passages are dicta from the *background sections* of those cases and were not otherwise part of the courts' analyses or holdings. (*See* Resp. 8-9.) The cases' *holdings* do not speak to the issues here. All but two of the cases address whether a particular law is preempted by ERISA or other legislation. *See Miller*, 538 U.S. at 332; *Prudential*, 413 F.3d at 902; *Quality Infusion Care Inc. v. Humana Health Plan of Tex. Inc.*, 290 F. Appx. 671, 673 (5th Cir. 2008); *Am. Drug Stores, Inc. v. Harvard Pilgrim Health Care, Inc.*, 973 F. Supp. 60, 61 (D. Mass 1997). Of the remaining cases, one addressed procedural doctrines on a motion to dismiss, and the other considered whether a physicians' network was subject to the state's AWP law. *High Mountain Corp. v. MVP Health Care, Inc.*, 416 F. Supp. 3d 347, 349-50 (D. Vt. 2019); *Idaho Cardiology Assocs., P.A. v. Idaho Physicians Network, Inc.*, 108 P.3d 370, 371 (Idaho 2005).

In sum, none of Plaintiffs' cases support their conclusion that South Dakota's AWP Law (or all AWP laws) are intended "to impair an insurer's ability to limit the number of providers in the insurer's plan networks." (Resp. 13.) Unlike the foreign laws upon which Plaintiffs rely, South Dakota's AWP Law does not vest rights in physicians or private medical practices like Plaintiffs. Rather, South Dakota's law ensures that *patient choice* is not obstructed by insurers excluding providers from *the insurers' panel of providers*. SDCL 58-17J-2; (Br. 14-18; 25-28). Plaintiffs' reliance on the laws of these other states is misplaced.

II. The Presumption Against Implied Repeal Requires Reversal.

Plaintiffs concede that the AWP Law must be construed harmoniously with existing provisions of South Dakota's Insurance Code. (Resp. 19.) The circuit court's decision, however, conflicts with numerous provisions of the Insurance Code that expressly permit focused and tiered plans. (Br. 18-24.) Plaintiffs' efforts to reconcile their interpretation with these laws do not succeed.

First, Plaintiffs assert that focused and tiered plans would still exist under their interpretation because "plans will remain closed to providers outside of the plan's geographic coverage area" and to providers unwilling to meet the plan's terms and conditions. (Resp. 20; *see* R. 1273.) But open and closed plans are no different in this regard. Even open plans are limited by geographic region and acceptance of reimbursement rates, so this supposed distinction between open and closed plans is meaningless. (Br. 22-23.)

Second, Plaintiffs contend that focused and tiered plans could still exist under their interpretation because a health insurer could still exclude providers who are not on the insurer's panel of providers and provide no benefits for out-of-network services. (Resp. 19-21.) But as SHP explained in its opening brief, this argument is circular. (Br. 23 n.4.) The South Dakota Insurance Code defines a "closed plan" as one that "requires covered persons to use participating providers … and does not provide any benefits for out-of-network services…." SDCL 58-17F-1(1); *see* SDCL 58-17G-1(1); SDCL 58-17I-1(8). The reason closed plans provide no benefits for out-of-network services is precisely because South Dakota law allows insurers to exclude providers, and to direct patients to

only those providers who are in-network. Plaintiffs' interpretation eliminates insurers' statutory right to selectively contract with providers to create the benefits of focused plans—which include lower premiums for patients.

Third, Plaintiffs' try but fail to reconcile their position with SDCL 58-17F-11(7). That statute expressly permits health insurers to terminate plan contracts with providers *without cause*. Plaintiffs' interpretation eliminates this statutory right because it prohibits insurers from excluding from their plans providers that meet the AWP Law's requirements. (*See* Br. 23.) Thus, under Plaintiffs' interpretation, an insurer would not have the same degree of freedom to terminate plan contracts with certain providers. Plaintiffs try to reconcile their interpretation by claiming that health insurers could still terminate a contract without cause as long as that termination is not "for the purpose of excluding the provider." (Resp. 21.) But that would still nullify insurers' rights under SDCL 58-17F-11(7) to terminate plan contracts for *any reason*, or for no reason at all. It would also make SDCL 58-17F-11(7) impossible to enforce, as courts would constantly have to adjudicate whether a particular termination was "for the purpose of excluding the provider." (*See* Resp. 11, 14; R. 1273-74.) SDCL 58-17F-11(7) cannot be reconciled with Plaintiffs' interpretation.

Finally, Plaintiffs concede that the conduct permitted by SDCL 58-17F and 58-41 would still be expressly prohibited by their interpretation of the AWP Law. (Resp. 21-22.) SDCL 58-17F-11(3) provides that a health insurer is not required to contract with every provider who meets its selection criteria, or with more providers than necessary to maintain network adequacy. SDCL 58-41-2 provides that no HMO, like SHP, is

prohibited from issuing contracts to insureds on a "preferred provider, exclusive provider, or closed panel basis." Plaintiffs maintain that those provisions can be reconciled because they state that their respective *chapters* do not prohibit HMOs from issuing contracts on a preferred provider, exclusive provider, or closed panel basis. (Resp. 21-22.) But even if there is no semantic conflict with these two provisions, the effect of Plaintiffs' interpretation would nullify these and all other provisions governing the use of closed plans because health insurers could no longer limit the size of their closed plans—as the statutes expressly allow them to do.

SHP's interpretation of the AWP Law accomplishes what Plaintiffs' does not: it harmonizes the AWP Law with the South Dakota Insurance Code. (*See* Br. 24.) Closed and open plans continue to exist, health insurers can still terminate particular plan contracts without cause, but health insurers may not exclude willing and qualified providers from participating on their panel of providers. The Court should therefore decline Plaintiffs' invitation to repeal several sections of South Dakota's Insurance Code. *See Faircloth v. Raven Indus., Inc.*, 2000 S.D. 158, ¶ 10, 620 N.W.2d 198, 202 (courts may negate a legislative act only if "it is demanded by manifest necessity" and the "Legislature's intent to do so must be apparent").[6]

* * *

[6] Contrary to Plaintiffs' argument, the later-in-time rule does not apply since the statutes can be reconciled under SHP's interpretation. *Faircloth*, 2000 S.D. 158, ¶ 10, 620 N.W.2d at 202; *Nat'l Farmers Union Prop. & Cas. Co. v. Bang*, 516 N.W.2d 313, 317 (S.D. 1994).

Because the circuit court's decision rewrites the plain text, thwarts the express purpose of the statute, and would impliedly repeal many provisions of the Insurance Code, it should be reversed.[7]

III. The Circuit Court Erred in Finding No Genuine Issue of Material Fact Exists Regarding Plaintiffs' Willingness to Accept SHP's Terms and Conditions.

The record is devoid of any evidence that Plaintiffs are willing to accept the terms and conditions that would be offered *to Plaintiffs* for participating in SHP's focused plans. This creates a genuine issue of material fact regarding Plaintiffs' willingness to accept SHP's terms, and the circuit court erred in granting summary judgment.

Plaintiffs try to avoid this entire issue by focusing on the protective order used in discovery below. Plaintiffs claim that an AEO designation prevented them from seeing the terms and conditions that they would be offered to join SHP's focused plans. (Resp. 23-27.) This argument is a red herring.

The undisputed record shows that the AEO designations applied to a contract that is *different* from terms and conditions that would be offered to Plaintiffs. The contract between SHP and Sanford Health—to which the AEO designation applied—governed Sanford Health's participation in SHP's plans, not Plaintiffs' participation. (*See* R. 233-92.) There is no evidence that the terms of that contract would apply to Plaintiffs. In fact,

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[7] As previously discussed, the circuit court interpreted the statute as plan-specific, not tier-specific, and therefore does not bar use of tiered networks as in SHP's PLUS plan. (Br. 17 n.3.) Plaintiffs complain that SHP had not previously argued that the circuit court's decision permits tiered plans. (Resp. 29 n.19.) But since SHP's appeal is its first opportunity to address the circuit court's decision, Plaintiffs' complaints are unfounded.

the undisputed record shows that the terms and conditions of that contract *would not be offered* to Plaintiffs. (R. 531 (¶ 14), 1214-15 (¶¶ 13-16).) Thus, whether Plaintiffs non-attorneys could review the Sanford Health-SHP contract is irrelevant.

First, the undisputed record shows that the terms and conditions for participating in SHP's plans are negotiated individually, by provider. (R. 531 (¶ 14), 1215 (¶ 16).) Such terms include much more than reimbursement rates. (*See, e.g.*, R. 233-92.) Many factors determine whether a provider should be in-network in a plan, including: quality of care programs, geography, range of services, outcomes, ability to service network need, cost efficiency, historical utilization, willingness to comply with utilization review, price, patient mix (including the number of uninsured and low-income patients served), compatibility of information technology, and size. (R. 528 (¶ 5).) The record shows that these can differ for Plaintiffs and for Sanford providers, and why that is so. (R. 1243 (¶ 11), 1214-16 (¶¶ 13-17); *see* R. 529-30 (¶¶ 6-8), 532 (¶¶ 24-26); *see also* R. 1212-14 (¶¶ 3-11.) Reimbursement rates also vary greatly by provider, particularly between full-service hospitals like some Sanford Health facilities and specialty hospitals like Plaintiff SFSH, which does not offer less-profitable (but necessary) services like 24-hour emergency care and trauma care. (R. 1214-15.) Terms offered to providers therefore vary. There is no evidence that the terms and conditions that SHP negotiated with Sanford Health are the same as, or even comparable to, those that would be available to Plaintiffs. In fact, the record—which Plaintiffs have not rebutted—shows that they are not available.

Second, the corporate representative for Plaintiff Ophthalmology Ltd. testified that he could not predict what terms and conditions SHP would offer to Ophthalmology

Ltd. (R. 1064-65.) He also stated *three times* that there are "lots" of terms that would cause Ophthalmology Ltd. to reject a contract with SHP. (R. 522 (¶¶ 63-64), 1064-67.) The circuit court erred by granting summary judgment in the face of this evidence.

This evidence directly contradicts Plaintiffs' counsel's representation to the circuit court that Plaintiffs would accept certain unknown terms and conditions—based solely on his review of the SHP-Sanford Health contract.[8] For the first time, Plaintiffs now identify a series of assumptions on which their purported willingness is based, including that: reimbursement rates in the Sanford Health contract appear greater than what Plaintiffs assume SHP would negotiate with Plaintiffs; SHP's reimbursement rates are purportedly greater than those from Medicaid and Medicare; and Plaintiffs allege that reimbursement rates were affected by SHP's and Sanford Health's corporate relationship. (Resp. 25.)

The record contains no evidence for these assumptions. Plaintiffs' assumptions also do not show that Plaintiffs would be willing to accept the terms and conditions that would actually be offered to them. Moreover, Plaintiffs' assumptions cannot overcome the evidence that there may be many terms or conditions to which at least one Plaintiff would not accept. *See Pessima v. Allen*, 2021 WL 1691143, at *5 (D.S.D. Apr. 29, 2021) ("[A] conclusory, self-serving affidavit will not defeat an otherwise meritorious summary

[8] Plaintiffs clarify that their counsel did *not* submit a sworn affidavit testifying that his clients would accept the terms of the SHP-Sanford Health contract. Rather, he said so in a brief to the circuit court. (Resp. 27 n.17.) To the extent such statements can be considered evidence rather than mere argument, it is outweighed by the sworn, unrebutted testimony of counsel's client Ophthalmology Ltd. (R. 522 (¶¶ 63-64); R. 1064-67.)

judgment motion."); *Frevert v. Ford Motor Co.*, 614 F.3d 466, 473-74 (8th Cir. 2010) (self-serving affidavit contradicting plaintiff's prior representations was insufficient to avoid summary judgment).

A genuine issue of material fact exists as to whether the Plaintiffs would accept the terms and conditions for SHP's focused plans. The circuit court's decision should be reversed.[9] *See Fisher v. Kahler*, 2002 S.D. 30, ¶ 11, 641 N.W.2d 122, 127.

IV. Plaintiffs' Public Policy Arguments Are Without Merit.

Plaintiffs incorrectly dismiss SHP's arguments as mere "public policy." SHP's position is not based on policy preference, but on the plain text and express purpose of the AWP Law, and on this Court's strong presumption against implied repeal of South Dakota statutes. (Br. 14-29); *see Steinberg*, 2000 S.D. 36, ¶ 15, 607 N.W.2d at 601-02. Specific record evidence shows that SHP's interpretation would fulfill the AWP Law's purpose, and that adopting Plaintiffs' interpretation would impair patient choice of providers by eliminating focused plans.[10]

Meanwhile, Plaintiffs spend nearly four pages arguing their own unsupported public policy views. Plaintiffs claim that SHP's interpretation of the AWP Law will result

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[9] If the Court concludes that the circuit court should be affirmed in full, SHP respectfully asks the Court to stay the effect of the circuit court's decision for eighteen months, which is the time necessary for SHP to restructure its plan offerings and ensure compliance with the Court's decision.

[10] The circuit court did *not* find this argument "disingenuous," as Plaintiffs suggest. (*See* Resp. 28.) Rather, the circuit court thought that SHP was arguing that the choice protected by the AWP Law was to go to an out-of-network provider and pay 100%. (R. 1267 n.2.) SHP never argued that was the meaning of "choice" under the statute.

in a dystopian future where for-profit private practitioners will vanish. (Resp. 28-31.) But Plaintiffs identify no record support for how the continued existence of focused plans will eliminate independent for-profit providers. (Resp. 30.) Indeed, the undisputed record refutes Plaintiffs' speculation, showing that nearly 70 percent of SHP's insureds already choose broad plans that include Plaintiffs. (R. 1214 (¶ 12).)

Finally, Plaintiffs' conjecture about Wellmark is new and unsupported by the record. (Resp. 30.) The record contains no evidence about Wellmark's business model, its panel of providers, or its benefit plans. Plaintiffs' argument about the cost of SHP's (or Avera's) focused plans relative to Wellmark's business model has no factual basis in the record and should be disregarded.

CONCLUSION

For the reasons stated above and in SHP's Opening Brief, Sanford Health Plan respectfully asks the Court to reverse the circuit court's decision, and to direct the circuit court to enter judgment in favor of SHP.

Dated at Sioux Falls, South Dakota, this 16 day of June, 2023.

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CERTIFICATE OF COMPLIANCE

The undersigned hereby certifies that the Reply Brief of Appellant Sanford Health Plan complies with the type volume limitations set forth in SDCL 15-26A-66(b)(2). Based on the information provided by Microsoft Word 2016, this Reply Brief contains 4,981 words, excluding the Table of Contents, Table of Authorities, any addendum materials, and any Certificates of counsel. This Brief is typeset in Times New Roman (12 point) and was prepared using Microsoft Word 2016.

Dated at Sioux Falls, South Dakota, this 16 day of June, 2023.

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