

FILED

JAN 17, 2014

Hearings Unit, OIC  
Patricia D. Petersen  
Chief Hearing Officer

STATE OF WASHINGTON  
BEFORE THE WASHINGTON STATE  
OFFICE OF THE INSURANCE COMMISSIONER

In the Matter of:

Seattle Children's Hospital Appeal of OIC's  
Approvals of HBE Plan Filings.

Docket No. 13-0293

DECLARATION OF MICHAEL  
MADDEN IN SUPPORT OF SEATTLE  
CHILDREN'S HOSPITAL'S MOTION  
FOR PARTIAL SUMMARY  
JUDGMENT

I, Michael Madden, declare as follows:

1. I am an attorney with Bennett Bigelow & Leedom, P.S., and counsel for Plaintiff Seattle Children's Hospital in this matter. I make this declaration based on my personal knowledge and am competent to testify herein.

2. Attached hereto are true and correct copies of the following:

**Exhibit A** is a true and correct copy of Seattle Children's Hospital's First Requests for Admission to the Office of the Insurance Commissioner with Responses.

**Exhibit B** is a true and correct copy of Seattle Children's Hospital's First Interrogatories and Requests for Production to the Office of the Insurance Commissioner with Answers.

**Exhibit C** is a true and correct copy of the Motion of Insurance Commissioner Mike Kreidler for Reconsideration of Findings of Fact, Conclusions of Law, and Final Order, dated September 6, 2013, in In re: Coordinated Care Corporation, Docket No. 13-0232.

**Exhibit D** is a true and correct copy of the Order on OIC's Motion for Reconsideration, dated November 15, 2013, in In re: Coordinated Care Corporation, Docket No. 13-0232.

DECLARATION OF MICHAEL MADDEN RE:  
SEATTLE CHILDREN'S HOSPITAL'S  
MOTION FOR PARTIAL SUMMARY JUDGMENT - 1  
Docket No. 13-0293

LAW OFFICES  
BENNETT BIGELOW & LEEDOM, P.S.  
601 Union Street, Suite 1500  
Seattle, Washington 98101  
T: (206) 622-5511 F: (206) 622-8986

I DECLARE, under penalty of perjury under the laws of the state of Washington, that the foregoing is true and correct.

Executed at Seattle, Washington this 17 day of January, 2014.



MICHAEL MADDEN, WSBA # 8747

DECLARATION OF MICHAEL MADDEN RE:  
SEATTLE CHILDREN'S HOSPITAL'S  
MOTION FOR PARTIAL SUMMARY JUDGMENT - 2  
Docket No. 13-0293

LAW OFFICES  
BENNETT BIGELOW & LEEDOM, P.S.  
601 Union Street, Suite 1500  
Seattle, Washington 98101  
T: (206) 622-5511 F: (206) 622-8986

**CERTIFICATE OF SERVICE**

I certify that I served a true and correct copy of this document on all parties or their counsel of record on the date below by hand delivery on today's date addressed to the following:

**Hearings Unit**

Honorable Mike Kreidler  
[KellyC@oic.wa.gov](mailto:KellyC@oic.wa.gov)  
Office of the Insurance Commissioner  
Hearings Unit  
5000 Capitol Boulevard  
Tumwater, WA 98501

**Office of the Insurance Commissioner**

Charles Brown  
[charlesb@oic.wa.gov](mailto:charlesb@oic.wa.gov)  
Office of the Insurance Commissioner  
5000 Capitol Boulevard  
Tumwater, WA 98501

**Coordinated Care Corporation**

Maren R. Norton  
Gloria S. Hong  
[mrnorton@stoel.com](mailto:mrnorton@stoel.com)  
[gshong@stoel.com](mailto:gshong@stoel.com)  
Stoel Rives LLP  
600 University Street, Suite 3600  
Seattle, WA 98101

**Premera Blue Cross**

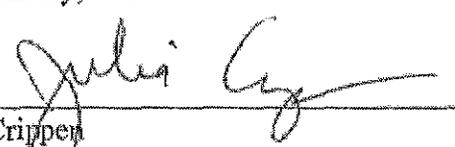
Gwendolyn C. Payton  
Lane Powell PC  
[Payton@lanepowell.com](mailto:Payton@lanepowell.com)  
1420 Fifth Avenue, Suite 4200  
Seattle, WA 98101-2375

**BridgeSpan Health Company**

Timothy J. Parker  
Carney Badley Spellman, P.S.  
[parker@carneylaw.com](mailto:parker@carneylaw.com)  
701 Fifth Avenue, Suite 3600  
Seattle, WA 98104-7010

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

Executed at Seattle, Washington, this 17th day of January, 2014.

  
\_\_\_\_\_  
Julia Crippen  
Legal Assistant

{0766.00018/M0950176.DOCX; 1}

DECLARATION OF MICHAEL MADDEN RE:  
SEATTLE CHILDREN'S HOSPITAL'S  
MOTION FOR PARTIAL SUMMARY JUDGMENT - 3  
Docket No. 13-0293

LAW OFFICES  
BENNETT BIGELOW & LEEDOM, P.S.  
601 Union Street, Suite 1500  
Seattle, Washington 98101  
T: (206) 622-5511 F: (206) 622-8986

# EXHIBIT A

**STATE OF WASHINGTON BEFORE  
THE WASHINGTON STATE  
OFFICE OF THE INSURANCE COMMISSIONER**

In the Matter of:

**Seattle Children's Hospital Appeal of OIC's**

**Approvals of HBE Plan Filing**

**Docket No. 13-0293**

**SEATTLE CHILDREN'S  
HOSPITAL'S FIRST REQUESTS  
FOR ADMISSION TO THE  
OFFICE OF THE INSURANCE  
COMMISSIONER WITH  
RESPONSES**

---

TO: Office of the Insurance Commissioner, care of  
Charles Brown, Attorney at Law  
5000 Capitol Boulevard  
Tumwater, WA 98501

Plaintiff Seattle Children's Hospital (SCH) propounds the following First Requests for Admission to the Office of the Insurance Commissioner (OIC).

**INSTRUCTIONS**

1. Please respond separately and fully, in writing, under oath, to the requests for admission set forth below and serve your responses upon the undersigned counsel for SCH within 30 days of service thereof at the offices of Bennett Bigelow & Leedom, P.S., 601 Union Street, Suite 1500, Seattle, Washington 98101. Unless responses are received in writing to these requests for admission within 30 days, the matters herein will be deemed admitted.
2. The OIC is required to respond to these requests for admission by and through any of its duly authorized representatives, agents, and attorneys who are competent to testify on its behalf and who know or have access to the information to which each request for admission relates. Each representative or agent preparing answers to these requests for admission is

SEATTLE CHILDREN'S HOSPITAL'S  
FIRST REQUESTS FOR ADMISSION  
TO THE OFFICE OF THE INSURANCE  
COMMISSIONER - 1  
Docket No. 13-0293

LAW OFFICES  
BENNETT BIGELOW & LEEDOM, P.S.  
601 Union Street, Suite 1500  
Seattle, Washington 98101  
T: (206) 622-5511 F: (206) 622-8986

required to affix his or her signature under oath to the answers to these requests, designating those particular requests to which he or she has prepared responses when there is more than one signatory.

3. These requests for admission are continuing, and the responses to these requests should be supplemented as new information becomes available.
4. If objection is made to any part of a request, please specify the part to which the objection applies.

#### DEFINITIONS

1. The words "document" or "documents" mean a writing or document of any kind or other tangible permanent record which is now, or formerly was, in the possession, custody or control of the plaintiff or his agents. The term "document" or "documents" includes, without limitation, correspondence, electronic mail ("e-mail"), stenographic, handwritten or other notes, memoranda, books, pamphlets, receipts, invoices, records, reports, charts, facsimiles, publications, contracts, agreements, tape or other recordings, computer print-outs, and every copy of every such writing or record where such copy contains any commentary or notation whatsoever that does not appear on the original.
2. To "identify" a person means to state the person's name, business and residence address, business and residence telephone numbers, occupation, job title; and dates employed; and if not an individual, state the type of entity, the address and telephone number of its principal place of business, and the name of its chief executive officer. To "identify" a document means to state the title of the document, the type of document (letter, memorandum, etc.), date of the document, and authors and recipients of the document.
3. As used herein, "and" as well as "or" shall be construed disjunctively or conjunctively as necessary to bring within the scope of the Request for Admission all responses that might otherwise be construed to be outside the scope.
4. As used herein, any reference to the singular shall include the plural and vice-versa to bring within the scope of the Request for Admission all responses that might otherwise be construed to be outside their scope.
5. As used herein, any reference to a particular gender shall be construed to include, both genders to bring within the scope of the Request for Admission all responses that might otherwise be construed to be outside their scope.

## REQUESTS FOR ADMISSION

**REQUEST FOR ADMISSION NO. 1:** 42 U.S.C. § 180310(c)(1) and 45 CFR § 156235(c) are applicable to the health plans that are the subjects of this appeal.

**RESPONSE:** Request for Admission No. 1 is denied in part and admitted in part. For further response to said request, OIC staff denies that the federal statute to which this request refers directly "applies" to the health plans that are the subject of this appeal since the statute is directed to the Secretary of the United States Department of Human and Health Services and to the criteria the Secretary is to establish for certifying health plans as qualified health plans. Request for Admission No. 1 is otherwise admitted.

**REQUEST FOR ADMISSION NO. 2:** Seattle Children's Hospital is an essential community provider, as defined in 42 U.S.C. § 180310(c)(1) and 45 CFR § 156.235(c).

**RESPONSE:** Request for Admission No. 2 is admitted.

**REQUEST FOR ADMISSION NO. 3:** The federal Centers for Medicare and Medicaid Services has identified Seattle Children's as an essential community provider for purposes of 42 U.S.C. § 1803.10(c)(1) and 45 CFR § 156.235(c).

**RESPONSE:** Request for Admission No. 3 is admitted.

**REQUEST FOR ADMISSION NO. 4:** At the time it approved the rate and form filings for the Exchange plans submitted by Coordinated Care Corporation, Premera Blue Cross, and BridgeSpan Health Company, these companies did not include Seattle Children's Hospital with their health insurance plan networks.

**RESPONSE:** Request for Admission No. 4 is denied as to Premera Blue Cross and admitted as to BridgeSpan Health Company and Coordinated Care Corporation as to which the request is admitted.

**REQUEST FOR ADMISSION NO. 5:** Seattle Children's Hospital is one of only two children's hospitals, as defined in 42 USC § 256(b)(a)(4)(M), located in Western Washington.

**RESPONSE:** Request for Admission No. 5 is admitted.

**REQUEST FOR ADMISSION NO. 6:** Prior to approving the rate and form filings for the Exchange plans submitted by Coordinated Care Corporation, Premera Blue Cross, and BridgeSpan Health Company, the Office of Insurance Commissioner did not have any evidence

before it sufficient to make a determination whether Seattle Children's Hospital had refused to accept the generally applicable payment rates of such plans.

**RESPONSE:** Request for Admission No. 6 is denied.

**REQUEST FOR ADMISSION NO. 7:** Prior to approving the rate and form filings for the Exchange plans submitted by Coordinated Care Corporation, Premera Blue Cross, and BridgeSpan Health Company, the Office of Insurance Commissioner did not have any evidence before it sufficient to make a determination whether Seattle Children's Hospital was unwilling to contract with these plans under reasonable terms and conditions.

**RESPONSE:** Request for Admission No. 7 is denied.

**REQUEST FOR ADMISSION NO. 8:** Prior to its approval or filing of the rate request filings for the Exchange plans submitted by Coordinated Care Corporation, Premera Blue Cross, and BridgeSpan Health Company, the Office of the Insurance Commissioner did not have any information, except as provided by these plans, concerning whether "spot contracting" or the like is a sufficient substitute for inclusion of SCH in the Exchange plan networks.

**RESPONSE:** Request for Admission No. 8 is denied.

**REQUEST FOR ADMISSION NO. 9:** Prior to its approval or filing of the rate request filings for the Exchange plans submitted by Coordinated Care Corporation, Premera Blue Cross, and BridgeSpan Health Company, the Office of the Insurance Commissioner did not "ensure that the [Exchange] plan covers the ten essential health benefits categories specified in section 1302 of P.L. 111-148 of 2010, as amended."

**RESPONSE:** Request for Admission No. 9 is denied.

**REQUEST FOR ADMISSION NO. 10:** Prior to its approval or filing of the rate request filings for the Exchange plans submitted by Coordinated Care Corporation, Premera Blue Cross, and BridgeSpan Health Company, the Office of the Insurance Commissioner did not "ensure that health plan enrollees ... [h]ave sufficient and timely access to appropriate health care services, and choice among health care providers."

**RESPONSE:** Request for Admission No. 10 is denied.

**REQUEST FOR ADMISSION NO. 11:** Prior to its approval or filing of the rate request filings for the Exchange plans submitted by Coordinated Care Corporation, Premera Blue Cross, and BridgeSpan Health Company, the Office of the Insurance Commissioner did not make a determination whether these Exchange plan networks were "sufficient in numbers and

types of providers to assure that all health plan services to covered persons will be available without unreasonable delay," to provide "[e]ach covered person" with "adequate choice among each type of health care provider," and to require these carriers to show "reasonable efforts to include providers and facilities in networks in a manner that limits the amount of travel required to obtain covered benefits," including pediatric services.

**RESPONSE:** Request for Admission No. 11 is denied.

**REQUEST FOR ADMISSION NO. 12:** Prior to its approval or filing of the rate request filings for the Exchange plans submitted by Coordinated Care Corporation, Premera Blue Cross, and BridgeSpan Health Company, the Office of the Insurance Commissioner did not have any information or document any review regarding whether these Exchange plan networks were "sufficient in numbers and types of providers to assure that all health plan services to covered persons will be available without unreasonable delay," to provide "[e]ach covered person" with "adequate choice among each type of health care provider," and to require these carriers to show "reasonable efforts to include providers and facilities in networks in a manner that limits the amount of travel required to obtain covered benefits," including pediatric services.

**RESPONSE:** Request for Admission No. 12 is denied.

**REQUEST FOR ADMISSION NO. 13:** In SCH FY 2012, SCH was responsible for 81.70% percent or more of all pediatric (ages 0-14) inpatient discharges within a 30-mile radius of the SCH facility.

**RESPONSE:** This request for admission alleges a medical statistic as to which the OIC staff has no knowledge or means of obtaining knowledge and which it therefore can neither admit nor deny.

**REQUEST FOR ADMISSION NO. 14:** In SCH FY 2012, SCH performed 100% of pediatric kidney and liver transplants, 90% of the pediatric ECMO procedures, 90% of the pediatric bone marrow transplants and 70% of the pediatric cardiac surgeries in Washington state.

**RESPONSE:** This request for admission alleges a medical statistic as to which the OIC staff has no knowledge or means of obtaining knowledge and which it therefore can neither admit nor deny.

**REQUEST FOR ADMISSION NO. 15:** In SCH FY 2012, SCH served patients from 34 of the state's 39 counties, and saw twice as many inpatients under the age of 15 as either of the state's other pediatric hospitals, Mary Bridge and Sacred Heart.

**RESPONSE:** This request for admission alleges a medical statistic as to which the OIC staff has no knowledge or means of obtaining knowledge and which it therefore can neither admit nor deny.

**REQUEST FOR ADMISSION NO. 16:** In SCH FY 2012, for hospitals within a 30-mile radius of SCH's facility, SCH treated 75% of all pediatric psychiatric inpatients, 81% of all pediatric inpatients, and over 90% of all high acuity pediatric inpatients.

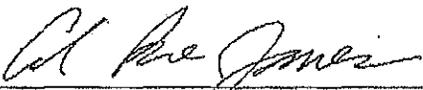
**RESPONSE:** This request for admission alleges a medical statistic as to which the OIC staff has no knowledge or means of obtaining knowledge and which it therefore can neither admit nor deny.

**REQUEST FOR ADMISSION NO. 17:** SCH is the sole provider in the state of Washington of the services identified in the attached Exhibit A.

**RESPONSE:** Denied. The OIC staff has no knowledge or means of obtaining knowledge whether some of the services listed on this exhibit are only available at SCH. See for example the statement on page two that "AP shunt care is not unique, though we have been the leader in infection reduction."

DATED this 11th day of December, 2013.

BENNETT BIGELOW & LEEDOM, P.S.

By   
Michael Madden, WSBA #08747  
Carol Sue Janes, WSBA #16557  
Attorneys for Plaintiff Seattle Children's  
Hospital.

SEATTLE CHILDREN'S HOSPITAL'S  
FIRST REQUESTS FOR ADMISSION  
TO THE OFFICE OF THE INSURANCE  
COMMISSIONER - 6  
Docket No. 13-0293

LAW OFFICES  
BENNETT BIGELOW & LEEDOM, P.S.  
601 Union Street, Suite 1500  
Seattle, Washington 98101  
T: (206) 622-5511 F: (206) 622-8986

ATTORNEY CERTIFICATION

RESPONSES AND OBJECTIONS SUBMITTED this \_\_\_\_\_ day of \_\_\_\_\_, 2014.

\_\_\_\_\_  
Charles Brown, WSBA #5555  
Attorney for Office of the Insurance Commissioner

SEATTLE CHILDREN'S HOSPITAL'S  
FIRST REQUESTS FOR ADMISSION  
TO THE OFFICE OF THE INSURANCE  
COMMISSIONER - 7  
Docket No. 13-0293

LAW OFFICES  
BENNETT BIGELOW & LEEDOM, P.S.  
601 Union Street, Suite 1500  
Seattle, Washington 98101  
T: (206) 622-5511 F: (206) 622-8986

VERIFICATION

I declare under penalty of perjury under the laws of the State of Washington that I am employed by the Washington State Office of the Insurance Commissioner, and am authorized to make the foregoing responses. I have read the foregoing Responses to Seattle Children's Hospitals' First Requests for Admission to the Office of the Insurance Commissioner, know the contents thereof, and believe them to be true and correct.

Dated 1/8, 2014.

Charles Brown

# EXHIBIT B

**COPY RECEIVED**

TIME \_\_\_\_\_ BY \_\_\_\_\_

JAN 09 2014

**BENNETT BIGELOW  
& LEEDOM**

**STATE OF WASHINGTON BEFORE  
THE WASHINGTON STATE  
OFFICE OF THE INSURANCE COMMISSIONER**

In the Matter of:

**Seattle Children's Hospital Appeal of OIC's  
Approvals of HBE Plan Filing**

**Docket No. 13-0293**

**SEATTLE CHILDREN'S  
HOSPITAL'S FIRST  
INTERROGATORIES AND  
REQUESTS FOR PRODUCTION  
TO THE OFFICE OF THE  
INSURANCE COMMISSIONER  
WITH ANSWERS**

TO: Office of the Insurance Commissioner, care of  
Charles Brown, Attorney at Law 5000 Capitol Boulevard  
Tumwater, WA 98501

Plaintiff Seattle Children's Hospital (SCH) propounds the following First Interrogatories and Requests for Production to the Office of the Insurance Commissioner (OIC).

**INSTRUCTIONS**

1. Please respond separately and fully, in writing, under oath, to the requests for admission set forth below and serve your responses upon the undersigned counsel for SCH within 30 days of service thereof at the offices of Bennett Bigelow & Leedom, P.S., 601 Union Street, Suite 1500, Seattle, Washington 98101. Unless responses are received in writing to these interrogatories within 30 days, any objections will be deemed waived.

2. The OIC is required to respond to these requests for admission by and through any of its duly authorized representatives, agents, and attorneys who are competent to testify on its behalf and who know or have access to the information to which each discovery request relates. Each representative or agent preparing answers to these interrogatories and requests for admission is required to affix his or her signature under oath to the answers to these requests, designating those particular requests to which he or she has prepared responses when there is more than one signatory.

SEATTLE CHILDREN'S HOSPITAL'S  
FIRST INTERROGATORIES AND REQUESTS  
FOR PRODUCTION TO THE COMMISSIONER - 1  
Docket No. 13-0293

LAW OFFICES  
BENNETT BIGELOW & LEEDOM, P.S.  
601 Union Street, Suite 1500  
Seattle, Washington 98101  
T: (206) 622-5511 F: (206) 622-8986

3. These interrogatories and requests for production are continuing, and the responses to these requests should be supplemented as new information becomes available.

4. If objection is made to any part of a discovery request, please specify the part to which the objection applies.

### DEFINITIONS

1. The words "document" or "documents" mean a writing or document of any kind or other tangible permanent record which is now, or formerly was, in the possession, custody or control of the plaintiff or his agents. The term "document" or "documents" includes, without limitation, correspondence, electronic mail ("e-mail"), stenographic, handwritten or other notes, memoranda, books, pamphlets, receipts, invoices, records, reports, charts, facsimiles, publications, contracts, agreements, tape or other recordings, computer print-outs, and every copy of every such writing or record where such copy contains any commentary or notation whatsoever that does not appear on the original.

2. To "identify" a person means to state the person's name, business and residence address, business and residence telephone numbers, occupation, job title, and dates employed; and if not an individual, state the type of entity, the address and telephone number of its principal place of business, and the name of its chief executive officer. To "identify" a document means to state the title of the document, the type of document (letter, memorandum, etc.), date of the document, and authors and recipients of the document.

3. As used herein, "and" as well as "or" shall be construed disjunctively or conjunctively as necessary to bring within the scope of the Request for Admission all responses that might otherwise be construed to be outside the scope.

4. As used herein, any reference to the singular shall include the plural and vice-versa to bring within the scope of the Request for Admission all responses that might otherwise be construed to be outside their scope.

5. As used herein, any reference to a particular gender shall be construed to include both genders to bring within the scope of the Request for Admission all responses that might otherwise be construed to be outside their scope.

## INTERROGATORIES AND REQUESTS FOR PRODUCTION

**INTERROGATORY NO. 1:** If your answer to SCH's First Requests for Admission (copy attached) Request for Admission No. 1 is "Deny," identify all facts which serve as the basis for your denial.

**ANSWER:** See Response to Request for Admission No. 1.

**INTERROGATORY NO. 2:** If your answer to SCH's First Requests for Admission (copy attached) Request for Admission No. 2 is "Deny," identify all facts which serve as the basis for your denial.

**ANSWER:** N/A

**INTERROGATORY NO. 3:** If your answer to SCH's First Requests for Admission (copy attached) Request for Admission No. 3 is "Deny," identify all facts which serve as the basis for your denial.

**ANSWER:** N/A

**INTERROGATORY NO. 4:** If your answer to SCH's First Requests for Admission (copy attached) Request for Admission No. 4 is "Deny," identify all facts which serve as the basis for your denial.

**ANSWER:** The HBE filings of all three issuers are available online through the OIC's web site. Also see letter dated September 19, 2013 from Waltraut Lehmann to Molly Nollette a copy of which was previously supplied to SCH and the Form A filings of these issuers copies of which are being provided.

**INTERROGATORY NO. 5:** If your answer to SCH's First Requests for Admission (copy attached) Request for Admission No. 5 is "Deny," identify all facts which serve as the basis for your denial.

**ANSWER:** N/A

**INTERROGATORY NO. 6:** If your answer to SCH's First Requests for Admission (copy attached) Request for Admission No. 6 is "Deny," identify all facts which serve as the basis for your denial.

**ANSWER:** Coordinated Care Corporation presented testimony in its appeal of the OIC's initial denial of its HBE plan filing concerning SCH's high rates. See for example the testimony of Dr Fathi. A recording of the testimony in that hearing is available online through the OIC's website.

**INTERROGATORY NO. 7:** If your answer to SCH's First Requests for Admission (copy attached) Request for Admission No. 7 is "Deny," identify all facts which serve as the basis for your denial.

**ANSWER:** See answer to Interrogatory No. 6.

**INTERROGATORY NO. 8:** If your answer to SCH's First Requests for Admission (copy attached) Request for Admission No. 8 is "Deny," identify all facts which serve as the basis for your denial.

**ANSWER:** See answer to interrogatory No. 7. Spot contracting was the subject of substantial testimony in the adjudicative proceeding in OIC Matter No. 13-0232. See the Findings of Fact, Conclusions of Law and Final Order in that matter and specifically Conclusion No. 12.

**INTERROGATORY NO. 9:** If your answer to SCH's First Requests for Admission (copy attached) Request for Admission No. 9 is "Deny," identify all facts which serve as the basis for your denial.

**ANSWER:** These filings may be viewed online at the OIC website. Each covers the ten essential health benefits specified in the Affordable Care Act.

**INTERROGATORY NO. 10:** If your answer to SCH's First Requests for Admission (copy attached) Request for Admission No. 10 is "Deny," identify all facts which serve as the basis for your denial.

**ANSWER:** The OIC reviewed the filings themselves for network adequacy and, in the case of Coordinated Care, conducted a multi day evidentiary hearing, much of which was devoted to the issue of network adequacy, before approving these filings. As reflected in the Findings of Fact, Conclusions of Law and Final Order in OIC Matter No. 13-0232, the OIC's final determination was that a pediatric specialty hospital need not be included within a carrier's network of precontracted providers.

**INTERROGATORY NO. 11:** If your answer to SCH's First Requests for Admission (copy attached) Request for Admission No. 11 is "Deny," identify all facts which serve as the basis for your denial.

**ANSWER:** See Answer to Interrogatory No. 10.

**INTERROGATORY NO. 12:** If your answer to SCH's First Requests for Admission (copy attached) Request for Admission No. 12 is "Deny," identify all facts which serve as the basis for your denial.

**ANSWER:** See answer to Interrogatory Nos. 6 through 11.

**INTERROGATORY NO. 13:** If your answer to SCH's First Requests for Admission (copy attached) Request for Admission No. 13 is "Deny," identify all facts which serve as the basis for your denial.

**ANSWER:** The OIC staff has no knowledge or information upon which to predicate a belief whether the statistic alleged in this Request is accurate or not.

**INTERROGATORY NO. 14:** If your answer to SCH's First Requests for Admission (copy attached) Request for Admission No. 14 is "Deny," identify all facts which serve as the basis for your denial.

**ANSWER:** The OIC staff has no knowledge and no information upon which to predicate a belief whether the statistic alleged in the Request is accurate or not.

**INTERROGATORY NO. 15:** If your answer to SCH's First Requests for Admission (copy attached) Request for Admission No. 15 is "Deny," identify all facts which serve as the basis for your denial.

**ANSWER:** The OIC staff has no knowledge and no information upon which to predicate a belief as to whether the statistic alleged in this requested admission is accurate or not.

**INTERROGATORY NO. 16:** If your answer to SCH's First Requests for Admission (copy attached) Request for Admission No. 16 is "Deny," identify all facts which serve as the basis for your denial.

**ANSWER:** The OIC staff has no knowledge and no information upon which to predicate a belief as to whether the statistic alleged in this requested admission is accurate or not.

**INTERROGATORY NO. 17:** If your answer to SCH's First Requests for Admission (copy attached) Request for Admission No. 17 is "Deny," identify all facts which serve as the basis for your denial.

**ANSWER:** The OIC staff has no knowledge and no information upon which to predicate a belief as to whether any of the services alleged in this requested admission, let alone all of them, can only be obtained in Washington from SCH. The list itself seems to belie the claim. See for example the statement on page two that "AP shunt care is not unique, though we have been the leader in infection reduction."

**REQUEST FOR PRODUCTION NO. 1:** Produce all documents used or referred to by you in answering the foregoing Interrogatories, and all other documents relevant to the subject matter of the action.

**RESPONSE:** The pertinent filings in this case are available on line through the OIC's web site. Also available on line through the OIC website are the pleadings and documents filed in OIC Matter No. 13-0232 and a recording of the hearing and testimony in that case. A copy of Ms. Lehmann's letter of September 13, 2013 was previously provided to SCH. If counsel requires an additional copy, please advise and the same will be provided. The certified status of these three health plans as qualified health plans is also documented on line at both the CMS and

SEATTLE CHILDREN'S HOSPITAL'S  
FIRST INTERROGATORIES AND REQUESTS  
FOR PRODUCTION TO THE COMMISSIONER - 8  
Docket No. 13-0293

LAW OFFICES  
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601 Union Street, Suite 1500  
Seattle, Washington 98101  
T: (206) 622-5511 F: (206) 622-8986

Washington Health Benefit Exchange web sites. Provided herewith are electronic copies of Instructions for the Essential Community Providers Application Section and a Letter to Issuers issued by CMS that are also available on line at the CMS web site, copies of emails regarding Seattle Children's status under Bridgestone's HBE plans. A CD containing the Form A filings of these three carriers is also provided herewith.

DATED this 11th day of December, 2013.

BENNETT BIGELOW & LEEDOM, P.S.

By \_\_\_\_\_  
Michael Madden WSBA #08747  
Carol Sue Janes, WSBA #16557  
Attorneys for Plaintiff Seattle Children's  
Hospital.

SEATTLE CHILDREN'S HOSPITAL'S  
FIRST INTERROGATORIES AND REQUESTS  
FOR PRODUCTION TO THE COMMISSIONER -- 9  
Docket No. 13-0293

LAW OFFICES  
BENNETT BIGELOW & LEEDOM, P.S.  
601 Union Street, Suite 1500  
Seattle, Washington 98101  
T: (206) 622-5511 F: (206) 622-8986

ATTORNEY CERTIFICATION

RESPONSES AND OBJECTIONS SUBMITTED this \_\_\_ day of \_\_\_\_\_ 2014.

\_\_\_\_\_  
Charles Brown, WSBA # 5555  
Attorney for Office of the Insurance Commissioner

SEATTLE CHILDREN'S HOSPITAL'S  
FIRST INTERROGATORIES AND REQUESTS  
FOR PRODUCTION TO THE COMMISSIONER -- 10  
Docket No. 13-0293

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VERIFICATION

I declare under penalty of perjury under the laws of the State of Washington that I am employed by the Washington State Office of the Insurance Commissioner, and am authorized to make the foregoing responses. I have read the foregoing Responses to Seattle Children's Hospitals' First Requests for Admission to the Office of the Insurance Commissioner, know the contents thereof, and believe them to be true and correct.

Dated January 8, 2014.

Charles Brown

# EXHIBIT C

MIKE KREIDLER  
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**FILED**

OFFICE OF  
INSURANCE COMMISSIONER

2013 SEP -6 P 4:34

BEFORE THE WASHINGTON STATE  
OFFICE OF THE INSURANCE COMMISSIONER  
Hearings Unit, DIC  
Patricia D. Peterson  
Chief Hearing Officer

In the Matter of:

**COORDINATED CARE  
CORPORATION,**

A Health Maintenance Organization.

Docket No. 13-0232

MOTION OF INSURANCE  
COMMISSIONER MIKE  
KREIDLER FOR  
RECONSIDERATION OF  
FINDINGS OF FACT,  
CONCLUSIONS OF LAW, AND  
FINAL ORDER

I. INTRODUCTION

The Office of the Insurance Commissioner ("OIC") respectfully requests reconsideration of portions of the Findings of Fact, Conclusions of Law, and Final Order in the above-captioned matter, entered on September 3, 2013, ("Final Order"). OIC disapproved the rate, form, and binder filings filed by Coordinated Care Corporation ("Coordinated Care") on July 31, 2013.

First, the Order failed to properly resolve the conflict with a decision on the merits, and instead impermissibly directed settlement. While the Final Order properly concludes that some bases upon which the OIC disapproved Coordinated Care's filings were "valid", the Order failed to resolve the conflict by issuing a determination. Rather, the Order required the OIC to enter into a type of settlement negotiation with Coordinated Care, to result in refiling, approval, and entrance into the Exchange. Such a directive is improper, exceeds the scope of administrative judicial authority, and is unsupported in law.



Second, the Final Order's conclusions rested upon improper admission of evidence of settlement negotiations in unrelated litigation.

Third, the Final Order contains errors of law that effectively force the OIC to permit Coordinated Care to enter the Exchange with an insufficient network based on a contract methodology that is contrary to the laws applicable to health maintenance organizations ("HMOs").

Fourth, the Final Order contains Findings of Fact about communication between Coordinated Care and the OIC during the proceedings that are not supported by an objective evaluation of the record.

Despite the objections described in this motion, the parties have complied with the directives in the Final Order. The OIC recognized that there was no meaningful opportunity to bring this Motion prior to engaging in that work if Coordinated Care's plans were to be approved for the Exchange. Out of respect for the judicial process, the OIC has worked cooperatively with Coordinated Care to resolve those items that the Final Order identified as "valid" bases for disapproval, and the plans that were the subject of the hearing have now been approved for certification by the Washington Health Benefit Exchange.

## II. ARGUMENT

### **A. The Final Order failed to resolve the matter with a decision on the merits, instead improperly directing settlement. In this, the Final Order exceeds administrative judicial authority, and is unsupported by law.**

The Final Order does not resolve this matter with a decision on the merits. Instead, that order commands OIC to allow the Company to revise its filings, provide

"reasonable guidance and recommended language" to the Company to correct its deficiencies, and "give prompt and reasonable approval of the Company's filings provided the Company has addressed the reasons for disapproval..." Final Order, at 22. It goes on to state, "this proceeding shall remain open until the Company has made new/amended filings," and to require the parties to notify the Hearing Officer of the disposition of those filings.

The Final Order cites no authority in the APA, the Insurance Code, or otherwise, which allows the Hearing Officer to refuse to rule on a matter, instead holding that matter open until a compulsory settlement, the terms of which are dictated by the Hearing Officer, has been reached.

While the APA does strongly encourage informal settlements, it does not compel settlement. See RCW 34.05.431(1), WAC 10-08-130(1)(g), and WAC 284-02-070(2)(d)(iv) (allowing for prehearing conferences for settlement or simplification); RCW 34.05.437(1) and WAC 10-08-130(5) (requiring presiding hearing officers to allow parties the opportunity to make offers of settlement); RCW 34.05.060, WAC 10-08-130(5), and WAC 10-08-230 (encouraging informal settlements). However, the APA "does not require any party or other person to settle a matter." RCW 34.05.060. See also CJC 2.6(B) (prohibiting judges from acting "in a manner that coerces any party into settlement.")

Further, there is no authority in the Administrative Procedures Act (Title 34.05 RCW), the Model Rules of Procedure (WAC 10-08), the Insurance Code (Title 48 RCW), the rules promulgated under the Insurance Code (WAC 284), or the letter delegating authority to Hearing Officer to preside over hearings, that authorizes the Hearing Officer,

or any other Administrative Law Judge, to force the Insurance Commissioner, or his duly appointed Deputy Commissioners and staff to settle matters that they have determined should not be settled, particularly with a carrier whose filings have in fact been found deficient.

Nor is there any authority which allows a Hearing Officer to be privy to - let alone monitor - settlement negotiations. Certainly there is no authority for a judge to dictate the terms of settlement and warn that failure to settle on those terms "would be to invite a consideration that the OIC might have erred in disapproving the Company's filings on July 31." That disapproval was either correct or it was not. The Final Order appropriately sets this forth as the precise issue before the Hearing Officer. "Therefore, most clearly stated, in this proceeding, the Company bears the burden of proving, by a preponderance of the evidence, that on July 31, 2013 the OIC erred in disapproving Coordinated Care Corporation's June 25, 2013 Bronze, Silver and Gold Individual Plan Filings for 2014." Final Order, at 10, ¶2. There is no authority cited, nor could there be, for the proposition that an Administrative Law Judge may change a legal ruling as punishment for one of the parties' failure to cooperate with directives in an Order.

The Hearing Officer clearly has authority to find that the OIC properly disapproved Coordinated Care's July 31 filings. In large part, the Final Order does acknowledge that the OIC's reasons for rejecting Coordinated Care's July 31 filings were valid. There is no question that, had the Hearing Officer found the OIC's reasons for disapproval were all invalid, she has the authority to find that the OIC improperly rejected the filings as they existed on July 31, and order the OIC to accept those filings as they existed at the time. The Hearing Officer arguably even has authority to conduct a

new review using a legal definition or understanding that did not exist, or was not used when the original review was conducted. But the Final Order does not compel the OIC to approve or disapprove the filings as they existed on July 31, or to conduct a new review in light of a new analysis on a question of law. Instead, the Final Order acknowledges that the filings were largely deficient for the reasons asserted by the OIC, but nonetheless compels the OIC to enter into settlement negotiations with Coordinated Care to assist Coordinated Care in amending its filings in order to become acceptable to the OIC. Similarly, the Final Order cites no express or implied statutory authority allowing - let alone compelling - the OIC to draft portions of the very documents and filings that the OIC is compelled to regulate.

The Final Order essentially asserts that because the OIC chose to settle with certain companies, it was required to offer settlement to this company, and then compels the OIC into that settlement, even dictating the terms of that settlement (that OIC was to "promptly review and/or suggest amended language which would meet any remaining concerns that the current language is misleading or does not comply with applicable rules"). See, e.g., Final Order, at 19. However, the Final Order cites absolutely no authority for this command. None exists.

In ordering the OIC to settle its disputes concerning Coordinated Care's filings, the Final Order creates two dangerous precedents. First, it compels the OIC to not only provide specialized and directed legal advice to a specific private company, but to effectively draft portions of their contracts. Because the OIC regulates those same contracts, the Final Order has essentially created a conflict of interest for the OIC. The Final Order has created the very real potential for Coordinated Care to claim at a future

date, that the OIC cannot take enforcement action against Coordinated Care concerning those contractual provisions, because the OIC itself drafted them.

Further, in compelling settlement with one carrier because the OIC entered into settlement discussions with a wholly separate and unrelated carrier, the Final Order set the dangerous precedent that the OIC is now *compelled* to settle with any carrier who challenges the OIC's disapproval of their network, rate, form, or binder filings. The Final Order effectively broadcasts to every health carrier in the state that, by demanding a hearing on any disapproved filing, they can force the OIC to fix their contracts for them, monopolizing staff time, and unilaterally rearranging the distribution of OIC resources. This is particularly problematic because with the open enrollment deadlines of the ACA, beginning with this year and moving forward, there will always be a deadline for health plans to be approved. Usurping the OIC's resources by compelling settlement negotiations will have potentially devastating effects on the OIC's ability to approve plans. This issue will only get worse, as more carriers and plans enter the exchange, and more plans are subject to the federal deadlines that for this year only apply to plans offered in the Exchange.

What the Final Order attempts to do is compel the OIC's discretion. The Final Order notes, "For the OIC to use its discretion in allowing the Company to quickly make modifications now . . . is reasonable and permissible." Final Order at 22. However, the Hearing Officer does not have authority to compel the Commissioner's discretion, or that of his appointed Deputy Commissioners and staff. The Hearing Officer has authority to review decisions for compliance with the law, and to consider whether staff have *abused* their discretion. But no finding of an abuse of discretion was made in the record, nor was

evidence presented to meet the difficult showing that an agency has abused its discretion. In fact, the Final Order acknowledges that the OIC did the best it could under the unique and difficult circumstances imposed by the Affordable Care Act. Further, the Hearing Officer cannot rely on the OIC's decision not to enter into settlement negotiations as the basis for an abuse of discretion, because there is no legal requirement anywhere to compel the OIC to enter into settlement negotiations. While it may be permissible for the OIC to exercise its discretion in the manner suggested by the Hearing Officer, it is not permissible for a Hearing Officer to compel the exercise of that discretion in keeping with her own preferences.

OIC may be reading too much into the Final Order. The Final Order does state in several places that OIC is being compelled to re-write Coordinated Care's filings for it in light of the extraordinary situation presented by the fact that the Exchanges are an entirely new entity for which federal rules and guidelines were being promulgated even as the OIC was attempting to review plans for compliance with them. See, e.g., Final Order at 3, ¶3. The Final Order appropriately states that "it must be recognized that the specific situation involved in this particular review of the Company's filings is unique." Final Order, at 21.

It may be that such is the Hearing Officer's reasoning behind the directives in the Final Order, and is meant to apply only to Coordinated Care and only in this one, unique situation. If so, OIC urges the Hearing Officer to reconfigure the Final Order, making that abundantly clear. While the OIC stands behind its objections, the agency acknowledges that such a clarification would at least avoid the perils presented by reference to the Final Order as precedent.

**B. The Final Order's conclusions rest upon improper admission of evidence of settlement negotiations in unrelated litigation.**

OIC respectfully submits that the challenged directives in the Final Order rely on factual errors that 1) are supported solely by evidence of settlement negotiations introduced by the Hearing Officer, not by either party, and which should have been barred by ER 408, and 2) are not supported by the evidence in the record.

Over the OIC's objection, the Final Order relies on evidence that the OIC had entered into settlement negotiations with carriers in unrelated matters. Final Order at 8. Under Evidence Rule ("ER") 408, this information should never have been admitted into evidence, or considered by the Hearing Officer, in the Coordinated Care hearing.

ER 408 prohibits the admission of settlement negotiations for the purpose of proving liability. Although the Rules of Evidence are not strictly adhered to in administrative proceedings under the Administrative Procedures Act, Title 34.05 RCW ("APA"), they cannot be wholly ignored. RCW 34.05.452(2) still requires that a presiding hearing officer "shall refer to the Washington Rules of Evidence as guidelines for evidentiary rulings."

It is reversible error to admit evidence of settlement negotiations with third parties and in unrelated proceedings. *Grigsby v. City of Seattle*, 12 Wn.App. 453, 458, 529 P.2d 1167 (1975). In *Grigsby*, the plaintiff was a passenger in an automobile accident. *Id.* at 454. He settled with the driver of the car he was in, and subsequently sued the City of Seattle for negligent design, construction, and maintenance of the street. *Id.* The Court of Appeals found it was reversible error for the jury to be informed that the Plaintiff had settled with the driver. *Id.* at 458.

ER 408 does permit evidence of settlement negotiations for limited purposes, such as to prove bias, prejudice of a witness, negating claims of undue delay, or proving obstruction of justice. None of those claims were present in this case. In fact, the Hearing Officer found that the OIC witnesses were "credible, and presented no apparent biases." Final Order at 9-10. Nor was this presented by the OIC to negate claims of undue delay. No other exceptions to the prohibitions in ER 408 are present in the record.

Further, the APA provides that a "presiding officer shall not base a finding exclusively on such inadmissible evidence unless the presiding officer determines that doing so would not unduly abridge the parties' opportunities to confront witnesses and rebut evidence. The basis for this determination shall appear in the order." RCW 34.05.461. Here, the Final Order contains no such determination regarding the evidence presented by the Hearing Officer about settlement negotiations with other parties. On the contrary: the evidence of the OIC's settlement discussions with other carriers was not submitted by either party, but by the Hearing Officer herself. The Final Order cites no testimony or exhibit demonstrating the OIC's settlement negotiations with other carriers; Coordinated Care was apparently unaware of the OIC's settlement discussions with other carriers until the Hearing Officer introduced the subject. The OIC could only object; it had no opportunity to confront the Hearing Officer as a witness. She was not sworn in, and could not be questioned about basis for her conclusions that settlement talks with other carriers were relevant to this case, even though those carriers may have had entirely different licensure, filing deficiencies, or ability to promptly correct the problems in their filings.

The Hearing Officer's decision to not only consider, but inject, evidence of the OIC's settlement discussions in other proceedings as evidence that the OIC mishandled Coordinated Care's filings, also calls the Hearing Officer's impartiality into question. The Code of Judicial Conduct (CJC), though not binding on administrative law judges, is instructive to the extent it sets out the standards for judicial conduct in the State of Washington. Further, the APA provides that "Any individual serving or designated to serve alone or with others as presiding officer is subject to disqualification for bias, prejudice, interest, or any other cause provided in this chapter or for which a judge is disqualified." RCW 34.05.425(3). CJC 2.11(a) provides that "A judge shall disqualify himself or herself in any proceeding in which the judge's impartiality might reasonably be questioned", particularly in several specific circumstances. For example, when a judge has "personal knowledge of facts that are in dispute in the proceeding," or is "likely to be a material witness in the proceeding," that judge is obligated to recuse him or herself. CJC 2.11(1), (2)(d). By presenting the evidence of the OIC's settlement negotiations, the Hearing Officer essentially made herself a material witness concerning disputed factual allegations. In doing so, she has called into question her own partiality concerning this and every case involving the OIC's denial of a carrier's rate, form, and binder filings.

Impartiality by a judge and improper testimony by a witness both constitute grounds for granting a CR 59 motion for retrial or reconsideration on the basis of irregularity in the proceeding. *Edwards v. Le Duc*, 157 Wn.App. 455, 460, 238 P.3d 1187 (2010) (finding a CR 59 motion appropriate where the trial court demonstrated partiality repeatedly during the trial.); *Storey v. Storey*, 21 Wn.App. 370, 375, 585 P.2d

183 (1978) (finding a witness' testimony regarding inadmissible evidence a grounds for granting a CR 59 motion).

Because the Hearing Officer's presentation and admission of evidence of the OIC's settlement negotiations was improper under RCW 34.05.452(2), RCW 34.05.461, ER 408, and CJC 2.11, the Final Order should be reconsidered, omitting this improperly admitted information and the directives based upon it.

**C. The Final Order contains errors of law that effectively force the OIC to permit Coordinated Care to enter the Exchange with an insufficient network, contrary to the laws applicable to health maintenance organizations.**

In addition to improperly compelling settlement, the Final Order compels the acceptance of an inadequate network, in violation of the law.

Concerning the adequacy of Coordinated Care's network, the Final Order makes two legal errors. First, it erroneously conflates Coordinated Care's unchallenged Medicaid network as an "adequate network" for commercial products that, unlike Medicaid, must provide for 10 essential health benefits. Unfortunately, the Final Order does not provide its statutory or legal basis for the conclusion that a Medicaid network is automatically adequate for a commercial policy. Apparently, the Final Order misconstrues the provision of WAC 284-43-200, which provides that evidence of compliance with network standards for public purchasers "may be used to demonstrate sufficiency" to mean that, if a carrier has a Medicaid network for its Medicaid products, it has by operation of law demonstrated compliance with network standard for public purchaser concerning every service provided under the carrier's commercial contracts, regardless of whether public purchasers are required to include those services or providers. **This is particularly important for Medicaid carriers whose Medicaid**

plans do not have to offer all of the ten essential health benefits required under the ACA. Those ten essential health benefits are further defined by the state benchmark plan, and the rules promulgated by the OIC and the federal government. There is no discussion in the Final Order demonstrating that Coordinated Care's Medicaid plan, and Medicaid network, cover all of the essential health benefits required by law. Without such a determination, the existence of Coordinated Care's Medicaid network cannot demonstrate an adequate network for purposes of its commercial products.

In addition, the network Coordinated Care filed for its commercial products, and that was reviewed by the OIC, was **not Coordinated Care's Medicaid network**. The testimony and evidence at the hearing demonstrate that while the network filed by Coordinated Care was intended to include its Medicaid providers, it was a network built by Coordinated Care expressly for its Exchange plans. That is why the Company was contracting with HealthWays to include some of its providers in the new network, evidence of which was introduced and admitted without objection. It is because Coordinated Care's commercial network was not identical to its Medicaid network that the OIC was reviewing the network in the first place.

The second error the Final Order makes concerning Coordinated Care's network is to order the OIC to allow an HMO to satisfy its obligations to provide essential health benefits through non-networked providers. This is an express violation of RCW 48.46.030. The statutes governing HMOs require that to be licensed as an HMO, a carrier must provide:

comprehensive health care services to enrolled participants on a group practice per capita prepayment basis or on a prepaid individual practice plan and provide[] such health services either directly or through

arrangements with institutions, entities, and persons which its enrolled population might reasonably require as determined by the health maintenance organization in order to be maintained in good health . . .

RCW 48.46.030(1). Providing all covered services either directly, or through contracted providers, is a requirement for licensure as an HMO. Both Coordinated Care and the Final Order ignore this fundamental requirement for HMOs. Compelling the OIC to permit Coordinated Care to refuse to contract with the only facilities that can provide certain services that are covered by Coordinated Care's plans, forces the OIC to violate the law by licensing a carrier as an HMO that does not meet the requirements to be one.

OIC respectfully requests that the final order be revised in order to avoid forcing the OIC to take actions that are contrary to law in the future.

**D. The Final Order contains Findings of Fact about communication between Coordinated Care and the OIC during the proceedings that are not supported by an objective evaluation of the record.**

The Final Order contains the erroneous factual conclusion that OIC improperly refused to communicate with Coordinated Care following the July 31, 2013 denial. The Order moreover states that the OIC informed Coordinated Care that "the OIC was prohibited from communicating with the company because the Company had filed a Demand for Hearing," states that the OIC acted disingenuously in making this alleged statement, and scolded the OIC for failing to properly inform Coordinated Care of an alleged policy of refusing to communicate after a Demand for Hearing is filed. Final Order at 7-8.

There is no testimony in the record as to a policy of refusing to communicate. Dr. Fathi testified as to his understanding that OIC staff refused to communicate with

Coordinated Care because it was "against the law" to talk to a party during a hearings process. This reflects a layman's understanding of the situation, and the OIC refuted his claim. The OIC never stated it had a "policy" of refusing to communicate with carriers in litigation, or that the law prohibits the OIC from doing so. *See* Final Order at 8 and 12.

There is no such policy. Rather, as demonstrated by counsel for the OIC, both staff attorney Andrea Philhower and Deputy Commissioner AnnaLisa Gellermann, the OIC, facing impending expedited litigation, reasonably required the company to direct its discussions solely to the legal affairs staff that would be handling that litigation. This requirement is based upon Rule of Professional Conduct ("RPC") 4.2, a ubiquitous standard that is immediately put in place by any attorney representing any party in litigation.

Generally, RPC 4.2 also limits client discussions with parties known to be represented. *See* RPC 4.2, comment 7. This entirely reasonable direction provided Coordinated Care with a meaningful avenue to address its concerns, and utilized OIC's limited staff resources in the most efficient manner possible. Neither Coordinated Care, nor the Final Order cite to any authority that contravenes the Rules of Professional Conduct, or mandates that a party who is subject to litigation, participate in discussions concerning the subject of that litigation, without counsel present.

Because the findings that the OIC "refused" to communicate with Coordinated Care, and changed its reasoning for doing so, are not supported in the record, the Final Order should be reconsidered without these erroneous and unsupported findings, and the directives based upon them should be stricken.

### III. CONCLUSION

Because the Final Order rests on significant but erroneous conclusions of fact and law, that stemmed from irregularities in the hearing process, the OIC respectfully requests that the Final Order be reconsidered.

DATED this 6<sup>th</sup> day of September, 2013.



Andrea L. Philhower  
OIC Staff Attorney

# EXHIBIT D

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BEFORE THE STATE OF WASHINGTON  
OFFICE OF INSURANCE COMMISSIONER

In the Matter of	)	Docket No. 13-0232
	)	
<b>COORDINATED CARE CORPORATION,</b>	)	<b>ORDER ON OIC'S MOTION</b>
	)	<b>FOR RECONSIDERATION</b>
A Health Maintenance Organization,	)	
_____	)	

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### NATURE OF PROCEEDING

On July 31, 2013, the Insurance Commissioner ("OIC") disapproved Coordinated Care Corporation's ("the Company") July 25, 2013 binder, form and rate filing for its Bronze, Silver and Gold Individual Plan Filings for sales relative to the new Washington State Health Benefits Exchange for 2014. The reasons for the OIC's disapproval (also called "objections") are set forth in the OIC's July 31 Disapproval Letter. On August 13, the Company filed a Demand for Hearing to contest the OIC's disapproval, contending that some of the OIC's objections were not supported by law and/or were inconsistent with prior feedback from the OIC, and also contending that the OIC had not made some of these objections until the deadline date of July 31 which allowed the Company no time to resolve the issues or cure the deficiencies. Because the OIC requested an expedited hearing, after proper notification the hearing was held August 26, 27 and 28 and the undersigned entered her Findings of Facts, Conclusions of Law and Final Order ("Final Order") on September 3. Thereafter, on September 6 the OIC filed its Motion for Reconsideration of the Final Order ("Motion"), asserting that the Final Order *failed to resolve the matter with a decision on the merits ... exceeding administrative judicial authority ...; contained conclusions based upon improper admission of evidence of [the OIC's] settlement negotiations with other carriers; contained errors of law concerning network adequacy; and contains the erroneous factual conclusion that OIC improperly refused to communicate with Coordinated Care following the July 31, 2013 denial.* Finally, the OIC implies that the fact that the undersigned considered evidence of the OIC's communications with other carriers after July 31, but refused to communicate with the Company after July 31, might signify that the undersigned might be biased and prejudiced. On September 27 the Company filed its Response opposing the OIC's Motion for Reconsideration, asserting that the Final Order *resolved all matters at issue on the merits, fell well within the scope of the Chief Presiding Officer's authority, [and] correctly considered evidence of the OIC's settlement negotiations with other carriers....* Finally, the Company asserts that *The OIC's accusation that the Chief Presiding Officer is somehow biased or prejudiced [for considering evidence of the OIC's communications with other carriers but not with the Company] is completely unfounded ... [and further that] [t]he OIC presents no other evidence to suggest that Chief Presiding Officer was not impartial here.*

Therefore, in entering this Order on OIC's Motion for Reconsideration, the undersigned has carefully reviewed the OIC's arguments in its Motion for Reconsideration, Coordinated Care's Response in opposition to the OIC's Motion for Reconsideration, all applicable statutes, regulations and case law cited by the parties, the record of this proceeding and the entire hearing file. Each of the sections of the Final Order, and procedural issues, which the OIC contests in its Motion for Reconsideration is identified and considered in detail in the Analysis section below.

**Standard of Review of Motion for Reconsideration.** In its Motion for Reconsideration, the Insurance Commissioner does not identify the legal standards that govern motions for reconsideration. However, while Washington's Administrative Procedures Act, at RCW 34.05.470(1), authorizes "a petition for reconsideration, stating the specific grounds upon which relief is requested," it defers to the standard of review established by an agency through

ORDER ON OIC'S MOTION  
FOR RECONSIDERATION

13-0232

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rulemaking. The APA does not indicate the standard of review in the absence of agency rules on the matter, nor has the OIC adopted any such rules of its own. Given this dearth, state rules and standards governing motions for reconsideration should provide guidance here, particularly 1) Washington Civil Rule 59. Additionally, Washington courts often look to the decisions of other courts, even federal courts, for the persuasiveness of their reasoning when trying to decide similar matters, and for that reason it is also helpful to look for guidance to the federal law used by federal courts in Washington hearing civil matters, particularly 2) Fed. R. Civ. P. 59 and Local Rule 7(h).

- 1) Washington's state courts follow Civil Rule (CR) 59 when considering motions for reconsideration. CR 59(a) provides a list of nine specific grounds for granting motions for reconsideration, briefly: 1) irregularity in the proceedings; 2) misconduct; 3) accident or surprise; 4) newly discovered evidence that the moving party could not with reasonable diligence have discovered and produced at the trial; 5) passion or prejudice; 6) error in assessment of recovery; 7) that there is no evidence or reasonable inference from the evidence to justify the decision or that it is contrary to law; 8) error in law occurring at the trial and objected to at the time by the moving party; or 9) that substantial justice has not been done. Whether one of these grounds is met is "addressed to the sound discretion of the trial court and a reviewing court will not reverse a trial court's ruling absent a showing of manifest abuse of discretion." *Wilcox v. Lexington Eye Institute*, 130 Wn. App. 234, 241, 122 P.3d 729 (2005). Washington state courts also caution that a motion for reconsideration should not be used as a vehicle to get a "second bite at the apple." "CR 59 does not permit a plaintiff to propose new theories of the case that could have been raised before entry of an adverse decision." *Wilcox*, 130 Wn.App. at 241, citing *JDFJ Corp. v. Int'l Raceway, Inc.*, 97 Wn.App. 1, 7, 970 P.2d 343 (1999).
- 2) Washington federal courts view motions for reconsideration similarly, but the federal court standard more clearly emphasizes that such motions seek an "extraordinary" remedy that should normally be denied. This standard was recently set forth in a June 20, 2012 order by Judge Robert J. Bryan in the civil action *White v. Ability Ins. Co.*, No. 11-5737-RJB (W.D.Wash.):

Pursuant to Local Rules W.D. Wash CR 7(h)(a), motions for reconsideration are disfavored and will ordinarily be denied unless there is a showing of a) manifest error in the ruling, or b) facts or legal authority which could not have been brought to the attention of the court earlier, through reasonable diligence. The term "manifest error" is "an error that is plain and indisputable, and that amounts to a complete disregard of the controlling law or the credible evidence in the record." *Black's Law Dictionary* 622 (9<sup>th</sup> ed. 2009).

Reconsideration is an "extraordinary remedy, to be used sparingly in the interests of finality and conservation of judicial resources." *Kona Enters.*,

*Inc. v. Estate of Bishop*, 229 F.3d 877, 890 (9<sup>th</sup> Cir. 2000). “[A] motion for reconsideration should not be granted, absent highly unusual circumstances, unless the district court is presented with newly discovered evidence, committed clear error, or if there is an intervening change in the controlling law.” *Marlyn Nutraceuticals, Inc. v. Mucos Pharma GmbH & Co.*, 571 F.3d 873, 880 (9<sup>th</sup> Cir. 2009). Neither the Local Civil Rules nor the Federal Rule of Civil Procedure which allow for motions for reconsideration is intended to provide litigants with a second bite at the apple. A motion for reconsideration should not be used to ask a court to rethink what the court had already thought through – rightly or wrongly. *Defenders of Wildlife v. Browner*, 909 F.Supp. 1342, 1351 (D.Ariz. 1995). Mere disagreement with a previous order is an insufficient basis for reconsideration, and reconsideration may not be based on evidence and legal arguments that could have been presented at the time of the challenged decision. *Haw. Stevedores, Inc. v. HT & T Co.*, 363 F.Supp.2d 1253, 1269 (D.Haw. 2005). “Whether or not to grant reconsideration is committed to the sound discretion of the court. *Navajo Nation v. Confederated Tribes & Bands of the Yakima Indian Nation*, 331 F.3d 1042, 1046 (9<sup>th</sup> Cir. 2003).

**Burden of Proof and Issue at Hearing.** First, the OIC filed a Motion to Determine Burden of Proof at hearing, requesting entry of an order establishing that the Company bears the burden of proof in this case *and that the applicable standard is abuse of discretion or error of law*. The OIC's Motion to Determine Burden of Proof concerned virtually only which party has the burden of proof, and at the outset of the hearing the Company agreed with the OIC that the Company had the burden of proof.<sup>1</sup> Second, at the outset of the hearing the parties agreed that the Company must prove its case by a preponderance of the evidence. Third, at the outset of the hearing the parties also agreed on the issue at hearing. The burden of proof and issue at hearing was stated in Conclusion of Law No. 2 in the Final Order, was not raised by the OIC as an issue in its Motion herein, and remains correctly stated as follows: *[t]he Company bears the burden of proving, by a preponderance of the evidence, that on July 31, 2013 the OIC erred in disapproving Coordinated Care Corporation's June 25, 2013 Bronze, Silver and gold Individual Plan Filings for 2014.* [Emphasis in original.] In its pleadings and at hearing, the parties agreed that this issue requires an evaluation 1) of the Company's July 25, 2013 filing as it was made on July 25; and 2) of the OIC's July 31, 2013 disapproval of this filing as it was made on July 31.

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<sup>1</sup> Although in this Motion herein the OIC has not raised any issue regarding the application of the abuse of discretion or error of law standards, at the end of its Motion to Determine Burden of Proof the OIC simply stated *It is important to keep in mind that this is not a disciplinary case. The OIC does not seek to impose a penalty or revoke a license and no constitutional provisions demand heightened scrutiny of the agency's action. The OIC staff therefore respectfully submits that Coordinated Care Corporation as the party seeking relief ... must demonstrate an abuse of discretion or an error law in order to prevail.* In its Motion the OIC did not assert that in some types of activities the abuse of discretion standard might apply and in other activities the error of law standard might apply.

ANALYSIS-Discussion of Balance of Arguments and Evidence

It is important to note that, as shown in the Final Order, the undersigned's fair and thorough weighing of the Company's and the OICs arguments and evidence relative to some of the significant issues involved in this matter could only lead to a conclusion that the Company simply met its burden of proof at hearing on these issues. Although, as shown below, the OIC misconstrues some parts of the Final Order, at the same time the OIC seems to be contesting every issue which it believes was not decided in its favor and attacking the Final Order and its author for the outcome of this administrative hearing. Had the OIC presented clear, consistent arguments, along with sufficient evidence to support its arguments, then these issues might well have been decided differently in the Final Order. A more specific discussion of this situation is detailed further below, under the issues to which they pertain. However, most generally, the OIC presented three witnesses: 1) The OIC presented its OIC contract analyst Jennifer Kreidler, who reviewed the Company's filing from the beginning and either taught or participated in the OIC's many classes held to train carriers in making filings for their Exchange products which were compliant with the ACA and state laws. While very capable, she lacked legal knowledge and understanding in some areas and was unable to justify portions of her review and disapproval of the Company's filing; she also occasionally changed her testimony and interpretations of rules, and - particularly when questioned by opposing counsel on cross examination - was occasionally shown to have had no reasonable basis for her disapproval of some sections of the Company's filing (e.g. written notice requirement which was one of her bases for disapproval);

2) The OIC did not present Deputy Commissioner Beth Berendt, who (pursuant to Ms. Kreidler's testimony) was Ms. Kreidler's superior and had been in charge of the Company's filing from the beginning; who along with Ms. Kreidler met with the Company; who apparently made the bulk of the decisions regarding approval or disapproval of sections of the filing; and who was also the sole individual with whom the Company was allowed to communicate in the later stages of the process and up until July 31. Instead, the OIC presented Ms. Berendt's very recent replacement, Deputy Commissioner Molly Nollette, who testified she was not yet familiar with Affordable Care Act ("ACA") and had not been employed in her current position during most of the time when the OIC was reviewing the Company's filing and making decisions regarding approval or disapproval of various sections; and

3) Finally, the OIC also did not present its actuary, Lichion Lee, who (pursuant to Kreidler's and Jetha's testimony) had reviewed and made decisions on the Company's filing throughout the process. Instead, the OIC presented actuary Shirazali Jetha, who testified he had not been part of the OIC's review of the Company's filing and even at the time of his testimony he stated that he had not even reviewed the entire filing.

In contrast, the Company also presented three witnesses:

1) The Company presented Sara Ross, its Manager of New Products and Programs Operations, who had worked on the filing since its inception, had attended all or most of the OIC's training sessions, and had communicated in person and otherwise with the OIC throughout the entire filing process;

2) The Company also presented its actuary, Jason Nowakowski, who had worked on and indeed drafted most of all of the filing since its inception; and

3) The Company also presented Jay Fathi, M.D., who has substantial knowledge and years of experience in the area of access to and delivery of medical care, and who had been involved in and communicated with the OIC since the beginning (his further credentials are detailed below).

**OIC's Arguments.** The OIC presents four arguments in support of its Motion for Reconsideration. While some of the OIC's arguments are repeated in its arguments, they are each identified and addressed below under at least one of the OIC's arguments:

**I. (OIC's Argument No. 3 in support of its Motion for Reconsideration): The network adequacy issue. The OIC argues that the Final Order contains errors of law that effectively force the OIC to permit Coordinated Care to enter the Exchange with an insufficient network [Pediatric Specialty Hospitals and Level I Burn Units], contrary to the laws applicable to health maintenance organizations.**

In response, the network adequacy issue is perhaps the most significant issue in this proceeding. This issue questions whether the Company is required to include Pediatric Specialty Hospitals and Level I Burn Units in its network.<sup>2</sup>

**A. Network Adequacy: inclusion of Pediatric Specialty Hospital(s) and Level I Burn Unit(s).** As referenced in Analysis above, this issue involved a clear imbalance of arguments and evidence presented by the parties. The Company met its burden of proof to support its position. Had the OIC presented clearer and more focused arguments, and strong, adequate and consistent evidence to support its current position that Pediatric Specialty Hospitals and Level I Burn Units must be included in the Company's network then this issue may well have been decided differently. All efforts would have been made to allow and consider any evidence the OIC presented on this issue - from its qualified staff, other professionals, interested providers and parties - along with the Company's evidence.

Some evidentiary problems at hearing are summarized below:

(1) The OIC testified that its remaining network adequacy issues were that

<sup>2</sup> While the OIC does not identify Pediatric Specialty Hospitals and Level I Burn Units in its Motion herein, and although as detailed below the OIC presented conflicting testimony on this requirement, these were the only two types of providers identified by the OIC (at least at some points in the hearing) as still needing to be included in the Company's network. The OIC had originally also included massage therapists as needing to be included but by the end of the hearing, based upon evidence from the Company that massage therapists were already included, the OIC dropped its objection that no massage therapists were included in the Company's network. In addition, the OIC asserts that the Final Order "effectively forced" or "required" or "directed" the OIC to approve the Company's filing and/or to settle the issues herein with the Company; although this assertion is made in several sections of the OIC's Motion, it is addressed in section II.A. below.

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Pediatric Specialty Hospitals and Level I Burn Units were not included in the Company's network [testimony of Kreidler]. Relative to this issue, the Company presented clear argument and evidence, correctly, that neither RCW 48.46.030 nor WAC 284-43-200 specifically require it to include Pediatric Specialty Hospitals and Level I Burn Units in its network, but that instead WAC 284-43-200 requires that *A health carrier shall maintain each plan network in a manner that is sufficient in numbers and types of providers and facilities to assure that all health plan services to covered persons will be accessible without unreasonable delay.* The Company then presented clear evidence, uncontroverted by the OIC, to show that it can provide 99% of covered pediatric and burn services through its network providers which are non-Pediatric Specialty Hospitals and non-Level I Burn Units and that therefore the Company is in compliance with WAC 284-43-200. More specifically, the Company presented credible argument and evidence that in its network it has 8,000 providers; has at least 30 hospitals including Shriners' Hospital and Sacred Heart Medical Center in Spokane and Mary Bridge Children's Hospital in Tacoma; has all of the Providence network of providers and apparently all of the Swedish network of providers (accordingly to Dr. Faithi's testimony Providence and Swedish have merged and have the same negotiating committee); that it went to talk to - and contracted with - all willing providers in rural counties; and that its network covers 14 counties. This testimony was primarily from Jay Faithi, M.D., a family physician who worked for 14 years in community care clinics for Medicaid patients and the uninsured, then has worked for Swedish health services as its Director of Primary Care and currently remains there as an instructor in Swedish's family practice program. In contrast, the OIC did not object to this testimony, and presented no testimony of its own to contradict or raise a reasonable question about either the testimony or the individual physician presenting it (Dr. Faithi is CEO of the Company). Neither did the OIC present clear evidence of its own to controvert the Company's testimony or to support its current position that the Company cannot *maintain each plan network in a manner that is sufficient in numbers and types of providers and facilities to assure that all health plan services to covered persons will be accessible without unreasonable delay* even with its current network, or that the Company cannot comply with this rule unless it included Pediatric Specialty Hospital(s) and Level I Burn Unit(s) in its network. Indeed, the OIC even changed its own position on whether these two types of providers were or were not required to be included in the Company's network. Indeed, e.g., as discussed below, the OIC could not identify a single service that the Company's current network could not provide, except for NICU services which the Company had already identified in its filing.

(2) The OIC's position on whether RCW 48.46.030 or WAC 284-43-200 do or do not require that Pediatric Specialty Hospital(s) and Level I Burn Unit(s) be included in the Company's network was inconsistent. First, in its Hearing Brief, the OIC argued that RCW 48.46.030 and WAC 284-43-200 do require the Company to include Pediatric Specialty Hospitals and Level I Burn Units in its network [Hearing Brief, pgs. 9-12]. Second, at hearing the OIC first testified that RCW 48.46.030 and WAC 284-43-200 do require the Company to include Pediatric Specialty Hospitals and Level I Burn Units in

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its network [Testimony of Kreitler]. Third, on cross examination the OIC agreed, correctly, that these rules do not specifically require the Company to include Pediatric Specialty Hospitals and Level I Burn Units in its network [Testimony of Kreitler] but that WAC 284-43-200(1) requires that the Company *maintain each plan network in a manner that is sufficient in numbers and types of providers and facilities to assure all health plan services to covered persons will be accessible without unreasonable delay*. The OIC's witness [Kreitler] agreed that there is no statutory requirement for a pediatric specialty hospital to be included in the Company's network, agreed that it does not require that the services be provided in a hospital at all - not to mention a Pediatric Specialty Hospital. Importantly as well, on cross examination the OIC's witness could not identify any burn service or any pediatric services which would be available at a Pediatric Specialty Hospital that the Company's network (including Providence) could not also provide except for NICU Level 4 which the Company had already identified in its filing. [E.g., testimony of Kreitler (JK) on cross examination: Company: *That [NICU Level 4] is the only service they [the Company] have identified as an example of potentially one that wouldn't be available in the network?* JK: *Yes.* CC: *You don't know of any others?* JK: *No.*]

(3) The Company's clear, uncontroverted evidence showed that Dr. Faithi specifically asked the OIC whether Seattle Children's Hospital (a Pediatric Specialty Hospital) was required to be included in its network, and the OIC responded that the Company was not required to include Seattle Children's Hospital in its network. The Company also presented evidence that if the OIC had told it [the Company] that Children's was required to be in its network then it would have done so. [Dr. Faithi testified *I think globally, from our standpoint, there seemed to be a lack of clarity. There are very prescriptive network requirements in, for example, Medicaid, and those seem to be somewhat lacking in this realm. And so there was some ambiguity, again I think I already said in our testimony, if we were told "You are required ... to contract with Seattle Children's" then that would've been very clear and we would've done it. We would've made it happen. I asked that question and the answer was No.*] The OIC neither objected to admission of this evidence nor presented evidence of its own to controvert or even question this evidence.

(4) Although the OIC did not identify lack of Pediatric Specialty Hospitals, Level I Burn Units or any other providers or facilities in the Company's network as a reason for disapproval in its July 31 Disapproval Letter, it does state that under RCW 48.46.030 and WAC 284-43-200 the Company *is required to demonstrate it has adequate arrangements in place to ensure reasonable proximity to a contracted network of providers and facilities to perform services to covered persons under its contracted plans*. The OIC further advises that it had reviewed *Coordinated Care's Provider Network Form A, Access Plan, and GeoNetwork report, and determined the network does not have sufficient contracted providers and facilities in place to support the services set forth in the product*. As above, the OIC did not specify what providers were still required

to be included in the Company's network, at hearing the OIC advised that the remaining providers at issue herein were Pediatric Specialty Hospitals and Level I Burn Units although as above, the OIC's statements regarding this requirement, with unsupported evidence, were not sufficient to controvert the Company's argument and evidence presented.

(5) Finally, even if it were appropriate to present new evidence here on reconsideration, the OIC in this Motion still fails to argue - and certainly fails to provide evidence - that Pediatric Specialty Hospitals and Level I Burn Units must be included in the Company's network (indeed, in its Motion the OIC does not even mention Pediatric Specialty Hospitals and Level I Burn Units or otherwise identify just what services must be included in the Company's network). As stated above, had the OIC presented clear argument and evidence to support its current position that Pediatric Specialty Hospitals and Level I Burn Units must be included then this issue may well have been decided differently. All efforts would have been made to allow and consider any evidence the OIC presented on this issue - from its qualified staff, other professionals, interested providers and parties - along with the Company's evidence.

**B. Network Adequacy: can the Company's compliance with network adequacy standards for Medicaid participation be used to demonstrate network sufficiency required by WAC 284-43-200(1) for Exchange products?** In its Motion on this issue, as discussed above in Analysis -- Discussion of Balance of Evidence, the OIC seems to fail to recognize the primary importance of presentation of clear and persuasive argument and evidence concerning the proper interpretation and application of WAC 284-43-200(1) and (2); instead, the OIC simply argues that the Final Order misconstrues WAC 284-43-200(2). WAC 284-43-200 provides:

*(1) A health carrier shall maintain each plan network in a manner that is sufficient in numbers and types of providers and facilities to assure that all health plan services to covered persons will be accessible without unreasonable delay. Each covered person shall have adequate choice among each type of health care provider, including those types of providers who must be included in the network under WAC 284-43-205. ... Each carrier shall ensure that its networks will meet these requirements by the end of the first year of initial operation of the network and at all times thereafter.*

*(2) Sufficiency and adequacy of choice may be established by the carrier with reference to any reasonable criteria used by the carrier, including but not limited to: Provider-covered person ratios by specialty, primary care provider-covered person ratios, geographic accessibility, waiting times for appointments with participating providers, hours of operation, and the volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care. Evidence of carrier compliance with network adequacy standards that are substantially similar to those standards established by state agency health care purchasers (e.g., the state health care*

authority and the department of social and health services) and by private managed care accreditation organizations may be used to demonstrate sufficiency.

(3) In any case where the health carrier has an absence of or an insufficient number or type of participating providers or facilities to provide a particular covered health care service, the carrier shall ensure through referral by the primary care provider or otherwise that the covered person obtains the covered service from a provider or facility within reasonable proximity of the covered person at no greater cost to the covered person than if the service were obtained from network providers and facilities, or shall make other arrangements acceptable to the commissioner. ... [Emphases added.]

In its Motion, without identifying any section of the Final Order in support of its argument, the OIC incorrectly assumes that the Final Order *erroneously conflates* [the Company's] ... *Medicaid network as an 'adequate network' for commercial products* ... [and] argues that *the Final Order does not provide its statutory or legal basis for the conclusion that a Medicaid network is automatically adequate for a commercial policy. Apparently, the Final Order misconstrues the provision of WAC 284-43-200(2), which provides that evidence of compliance with network standards for public purchasers 'may be used to demonstrate sufficiency' to mean that, if a carrier has a Medicaid network for its Medicaid products, it has by operation of law demonstrated compliance with network standard [sic] for public purchaser concerning every service provided under the carrier's commercial contracts, regardless of whether public purchasers are required to include those services or providers.* The OIC goes on to argue that this is particularly important for Medicaid carriers whose plans do not have to offer all of the ten essential health benefits required under the ACA.

In response, first, the OIC has misread the Final Order. Although the OIC fails to point to any section of the Final Order which states what the OIC suggests, clearly WAC 284-43-200(2) does not conclude [e] *that a Medicaid network is automatically adequate for a commercial policy.* Nor does the Final Order *provide its statutory or legal basis for the conclusion* because the Final Order nowhere makes this conclusion. Second, of course the differences between Medicaid networks and ACA networks is an important distinction. The OIC fails to point to any portion of the Final Order which might support its argument here. At any rate, in consideration of the issues herein and entry of the Final Order, little weight was given to the fact that the Company had its network approved by the Washington State Health Care Authority for use in the Medicaid market, although certainly WAC 284-43-200(2) does provide that *sufficiency ... may be established by the carrier with reference to any reasonable criteria used by the carrier, including but not limited to ... the volume of ... specialty services available to serve the needs of covered persons requiring ... specialty care. Evidence of carrier compliance with network adequacy standards that are substantially similar to those*

*standards established by state agency health care purchasers (e.g., the state health care authority and the department of social and health services) ... may be used to demonstrate sufficiency. It is interesting to note as well, however, that at hearing, the OIC seems to have contradicted its position here, in testifying that standards for network adequacy are found in WAC 284-43-200, and that one of the ways to establish network adequacy is evidence of carrier compliance to network adequacy standards that are essentially similar to those standards established by state agency health care purchasers ... state health care authority. The OIC further testified that this was an available standard and [a]n acceptable standard which carriers can use to establish adequacy. [Testimony of Kreidler.]*

C. **Network Adequacy: can the Company use single case contracts for pediatric specialty and level 4 burn services?** Once again without identifying any specific section of the Final Order to which it objects, and without identifying the providers at issue as Pediatric Specialty Hospitals and Level I Burn Units, in its Motion the OIC asserts that the second error the Final Order makes regarding network adequacy concerns the Company's failure to contract with Pediatric Specialty Hospitals and Level I Burn Units and to instead use single case contracts in limited occasions.<sup>3</sup> Citing RCW 48.46.030(1), the OIC argues that a *fundamental requirement for HMOs* is that *all covered services must be provided either directly [e.g. Group Health] or through contracted [network] providers.*

In response, first, in the hearing and now in this Motion, the OIC fails to present a convincing argument that RCW 48.46.030(1) actually does prohibit HMOs from utilizing single case contracts. Second, the OIC ignores WAC 284-43-200(3), cited above, the regulation which implements RCW 48.46.030(1) written by and adopted by the OIC, which actually does expressly allow carriers to utilize out-of-network providers as long as the consumer is not put in a worse position. For this reason, once again, the undersigned considered the Company's argument and evidence against the OIC's argument and evidence in considering and entering the Final Order: in its Prehearing Brief the Company argued [Prehearing Brief at pg. 9-10], and at hearing presented evidence [Testimony of Fathi], that it can provide pediatric services, including hospital services, through its four children's specialty service providers and hospitals and argued that these providers can provide 99% of the services provided by Seattle Children's Hospital. [Company's Prehearing Brief at pg. 12-11; Testimony of Fathi.] While the Company acknowledged there may be rare, unique types of care that are not provided by its network facilities, it would provide those services through use of single case contracts, which it argued persuasively were allowed under WAC 284-43-200. Indeed, the Company raised evidence of a Regence contract that specifically handles provision of pediatric specialty services through single case contracts which was apparently approved by the OIC and currently on the market. Finally,

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<sup>3</sup> While the OIC does not identify Pediatric Specialty Hospitals and Level I Burn Units in its Motion herein, these were the only types of providers identified by the OIC as still needing to be included in the Company's network. The OIC had originally also included massage therapists as needing to be included but by the end of the hearing, based upon evidence from the Company that massage therapists were already included, the OIC dropped its objection that no massage therapists were included in the Company's network.

the Company went on to argue in its Prehearing Brief and in testimony at hearing that it believed the OIC's real complaint appears to be that it did not include Seattle Children's Hospital (the renowned Pediatric Specialty Hospital affiliated with University of Washington) in its network. In its Prehearing Brief the Company further asserted, and at hearing presented uncontroverted testimony, that in July 2013 the OIC expressly told the Company that it was not required to contract with Children's to have an adequate network [Testimony of Fathi] and that it would have contracted with Children's if the OIC had advised it that it was required to do so.  
[Testimony of Fathi.]

In contrast, at hearing the OIC did not clearly raise the distinction it now might be making in this Motion, i.e. that it is essential services, rather than other services, that cannot be provided through single case contracts. However, this was an argument that could have been made at hearing and was not. Further, at hearing, as above, the OIC was unable to name one type of pediatric specialty service or burn service that could not be provided by the Company's current network providers (except for Level 4 NICU, which the Company had already identified in its filing).

Therefore, consistent with its obligation to meet its burden of proof, from the outset of the hearing in its Prehearing Brief through the hearing, the Company presented argument and evidence to support its position that its network was sufficient to provide virtually all required services by its non-Pediatric Specialty Hospital and non-Level I Burn Unit network providers. [Testimony of Fathi.] The OIC did not object to the Company's argument or evidence presented, and presented virtually no evidence of its own to contradict the Company's argument and evidence. Indeed, the OIC's argument and testimony focused on whether the Company's network providers were in adequate locations, not the fact that the Company's network did not include Pediatric Specialty Hospitals or Level I Burn Units (consistent with that part of the OIC's testimony which changed to state that the rules do not specifically require inclusion of these providers in the Company's network). The issue of whether or not the Company is prohibited from utilizing single case contracts in limited situations, and apparently most particularly regarding provision of some types of pediatric specialty services and level 4 burn services, is simply another situation where, after the undersigned's fair and thorough weighing of the Company's and the OIC's arguments and evidence, the undersigned could only reach the conclusion that the Company met its burden of proof at hearing on this issue. Once again, as stated above, had the OIC presented clear argument and evidence to support its current position that Pediatric Specialty Hospitals and Level I Burn Units must be included then this issue may well have been decided differently. All efforts would have been made to allow and consider any evidence the OIC presented on this issue - from its qualified staff, other professionals, interested providers and parties - along with the Company's evidence.

II. (OIC Argument No. 1 in support of its Motion for Reconsideration): The OIC argues that the Final Order failed to resolve the matter with a decision on the merits, and instead improperly directed settlement between the OIC and Coordinated Care. In this, the OIC argues, the Final Order exceeds administrative judicial authority, and is unsupported by law.

A. The OIC asserts in several sections of its Motion that the Final Order *improperly directed settlement* and *ordered* the OIC to approve this filing and *required settlement* and therefore exceeded administrative judicial authority.

In response, as shown in the Final Order, had the OIC continued to disapprove this filing after entry of the Final Order, there were no consequences. At the outset of the hearing, the OIC proposed, and the Company agreed, and the OIC did not challenge in this Motion, that the issue in the proceeding was whether, on July 31, 2013 the OIC erred in disapproving Coordinated Care Corporation's June 25, 2013 filings. As specifically stated in the Final Order but ignored by the OIC in its Motion herein, the parties agreed that the undersigned must strictly consider this issue as it existed on July 31, i.e. the undersigned must consider 1) the wording of the Company's filings, as they existed on July 31; and 2) the OIC's reasons, as they existed on July 31, for disapproval of these filings. In other words, the OIC's post-July 31 reasons for its July 31 disapproval were not at issue in the proceeding and could have simply been excluded by the undersigned in deciding whether the OIC properly disapproved this filing on July 31.

Instead of simply excluding all of the OIC's post-July 31 objections, however, as is shown by a reading of the Final Order and as argued by the Company in its Response to OIC's Motion herein, **the instances where the undersigned recognized the OIC's concerns and determined that the OIC should at least allow the Company to address these concerns were limited to those new (post-July 31) concerns which at hearing the OIC was attempting to apply retroactively to justify its July 31 disapproval.** As above, while the OIC's post-July 31 reasons could have been excluded entirely, the undersigned recognized the OIC's post-July 31 reasons because:

(1) Reliance on only the OIC's reasons which were stated in its July 31, 2013 Disapproval Letter would have a distinctly increased likelihood of resulting in a Final Order which determined that the OIC had erred in disapproving the Company's July 31 filing (which apparently is why the OIC chose post-July 31 to present new or different reasons at hearing). This was done particularly in light of the fact that, pursuant to the Company's testimony at hearing and the OIC's acknowledgement of its process at that time, the OIC had refused to communicate with the Company since July 31 when the evidence showed that it had communicated with other carriers whose filings had been disapproved on July 31; and the Company had presented substantial evidence that it was ready and willing to communicate with the OIC and to change its July 31 filing to cure any of the OIC's remaining pre-July 31 or post-July 31 concerns if it knew what these

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remaining concerns were (it having also been found that some of the OIC's July 31 objections were so unclear as to render the Company unable to know what they were and thus how to address them). Even where these objections were clear, some were shown through direct and cross examination to be requirements which were not even supported by law. For example, while on July 31 one of the OIC's reasons for disapproval was that the Company's requirement of written notice to add covered individuals was its provision was "overly restrictive" when clarified by the OIC witness the OIC's objection was actually shown to not be supported by statute at all. [Conclusion of Law No. 11; *see also* Testimony of Kreitler.]

(2) The undersigned recognized the OIC's post-July 31 reasons in an effort to promote settlement as encouraged by the Administrative Procedure Act, Title 34 RCW, particularly in light of the issues discussed in 1) above. For example, on July 31 some of the OIC's reasons for disapproval were that specific provisions in the Company's filing were "too restrictive" or in conflict with specific laws, but post-July 31 (i.e. at hearing) the OIC changed these reasons to argue instead that those provisions were 'confusing and misleading.' [See, e.g., OIC Objections 7, 9, 12 set forth in OIC's July 31 Disapproval Letter; after July 31 the OIC abandoned these July 31 bases for disapproval by asserting new bases in their stead.] The OIC asserted new (post-July 31) reasons for a number of its July 31 objections as well. For these reasons, where the undersigned found that the OIC's post-July 31 reasons for disapproval had merit, the undersigned required the OIC to promptly review and/or suggest amended language that would address its concern.

Therefore, contrary to the OIC's assertions, as discussed in section A. above and as shown by a reading of the Final Order, specific determinations were made therein as to the validity of the OIC's July 31 reasons for disapproval which the OIC did not change or replace post-July 31 at hearing. Rather than simply being excluded altogether as could have been done, the undersigned handled the question of the validity of the OIC's new post-July 31 reasons in an effort to promote settlement as encouraged by as discussed in detail in A. above.

B. It appears the OIC argues in its Motion that the undersigned had authority only to decide 1) whether every section of the Company's filing was consistent with law or not; and 2) if the undersigned concluded that even one section of these filings was noncompliant with any applicable federal or state statutes or regulations on July 31 then the undersigned must uphold the OIC's disapproval of these filings, because even the OIC itself had no authority to approve a plan which contained even one section which is noncompliant with any applicable federal or state statutes or regulations on July 31. In its Motion herein, the OIC argues that because the undersigned did find there were some violations of those applicable rules (presumably based on the OIC's reasons post-July 31 as well as on July 31) then the undersigned should have upheld the OIC's disapproval, but that instead she *improperly directed settlement between the OIC and*

*Coordinated Care* [of those sections which she found to be noncompliant] ... and thereby exceeds administrative judicial authority....

In response, the OIC fails to recognize that at the outset of the hearing, the parties agreed, and Conclusion of Law No. 3 reflected, that the issue in this proceeding is whether on July 31, 2013 the OIC erred in disapproving the Company's July 25, 2013 filings. [See also Burden of Proof and Issue at Hearing section above.] Further, the OIC did not raise Conclusion of Law No. 3 as an issue in its Motion herein. As further stated in the Final Order at Conclusion of Law No. 3, which, again, the OIC did not raise as an issue in this Motion, [t]his [issue] *contemplates not only whether all sections of the filings comply with all applicable statutes and regulations ... but also whether the OIC's process of review was reasonable. ... a determination of the central issue herein must of necessity include not only whether the filings were in compliance with applicable rules but also must include some basic consideration of the review process which the agency conducted; ... this is particularly true where, as here, the Company raises significant issues regarding the review process and claims that process unreasonably restricted its opportunity to have its filings approved. Indeed, while the OIC argues that the only issue is whether the Company's filings are fully compliant with all applicable rules, at the same time the OIC spent far more time – literally hours – presenting written documents and oral testimony solely regarding its process of reviewing these Exchange filings, both in general and with regard to this Company's filings. Therefore, the OIC itself seems to contemplate that its review process is relevant to determination of the central issue herein.* [Emphasis in original.]

D. The OIC then states that [i]f the Final Order does state in several places that OIC is being compelled to re-write *Coordinated Care's* filings for it in light of the extraordinary situation presented by ... the Exchanges ... Final Order at pg. 3, paragraph 3. This statement is entirely without merit; nowhere does the Final Order "compel OIC to re-write *Coordinated Care's* filings for it." The OIC then urges the undersigned to "reconfigure the Final Order, making it abundantly clear that the specific situation involved in this particular review of the Company's filings is unique. This is not necessary, since much time and language is included in the Final Order to reflect the uniqueness of this situation, e.g., *the specific situation involved in this particular review of the company's filings is unique.* [Final Order, at 21.] Finally, although this is clear, the OIC need not be concerned that there will be *perils presented by reference to the Final Order as precedent* because, as the Company points out, decisions in these proceedings are not precedential. The OIC then predicts that *ordering the OIC to settle its disputes concerning this Company's filings ... compels the OIC to not only provide specialized and directed legal advice to a specific private company, but to effectively draft portions of their contracts and further that compelling settlement with one carrier because the OIC entered into settlement discussions with a wholly separate and unrelated carrier, the Final Order set the dangerous precedent that the OIC is now compelled to settle with any carrier who challenges the OIC's disapproval of their network, rate, form, or binder filings. The Final Order ... broadcasts to every health carrier in the state that, by demanding a hearing on any disapproved filing, they can force the OIC to fix their contracts for them, monopolizing staff time, and unilaterally rearranging the distribution of OIC resources.* Once again, the OIC is encouraged to read the

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Final Order carefully, to recognize its applicability to this unique situation, and to recognize that it is, in fact, *reading too much into the Final Order* (see below).

E. Finally, the OIC questions whether the *OIC may be reading too much into the Final Order*. The OIC is correct: the OIC is reading too much into the Final Order. The Final Order speaks for itself.

**III. (OIC's Argument No. 2 in support of its Motion for Reconsideration): The OIC argues that the Final Order's conclusions rest upon improper admission of evidence of the OIC's settlement negotiations with other carriers.**

Again citing no portion of either the Final Order or the proceedings to support its argument No. 2, the OIC argues generally that the Final Order's "challenged directives" 1) rely on factual errors that 2) are supported solely by evidence of the OIC's settlement negotiations with other carriers which was introduced by the Hearing Officer, not by either party, 3) which should have been barred by ER 408, and 4) which are not supported by the record. The OIC does not articulate just what "challenged directives" it is referring to, and what "factual errors" it is referring to so it can only be speculated what "factual errors" they were that were "not supported by the record." However, the matter of "introduction of evidence by the Hearing Officer," must be addressed, and then the meaning of the balance of this argument can only be guessed at and addressed. [OIC's Motion at pg. 8.]

In response, 1) Very definitively, no evidence at all was introduced by the undersigned in this proceeding. Insofar as is relevant here, all evidence of the OIC's negotiations with other carriers was introduced by the Company and in statements made by OIC counsel. Whereas the OIC argues that the undersigned introduced evidence, this is clearly not the case; beginning even prior to the hearing in the Company's brief, the Company has asserted that the OIC was treating it unfairly in many ways. The Company carried this issue throughout the hearing, and continued to support its assertions of unfair treatment, including its own testimony that the OIC had approved other carriers' filings after July 31 which it had disapproved on July 31 when it had refused to even talk to the Company after it had disapproved the Company's July 31 filing. For example, evidence presented by the Company on Day 3: Dr. Fathi: *I was told by Ms. Gellermann we weren't allowed to have conversations since the appeal [i.e. the Demand for Hearing was filed]. We have lots of ... every day. We've modified things since we got the rejection. We were told that we're not allowed to discuss this. ... I and the company are results and solutions oriented and so I want to take you through how that played out. Molly called me with the news on August 1 and within two days after consulting with outside counsel, our own internal persons, we decided to file the appeal. At the same time we pursued setting up a meeting with the commissioner. Two or three days later, Ms. Gellermann called me and said I've called you to say I understand you have filed an appeal and I need to let you know that we cannot talk to you, cannot talk to you about the appeal. As you may recall a few days later there was a window of a mythological extension of a few days, on a Wednesday in the morning there*

*was a note that said you have until Friday to refile things for plans that have been disapproved. For about 7 or 8 hours, during that time I left messages and sent emails to saying I'd like to withdraw our appeal as of right now because we want to make this work, we want to work with you [the OIC], we're willing to make any of the change that you [OIC] require. Before she could even respond to that we got another email that said we [OIC] changed our minds there is no extension. What's done is done. Officially it's closed. So at that point we made sure we refiled the appeal. Throughout the last few weeks I would've loved nothing more to work with Ms. Kreitler and ... to ... I have found out from the public website that all of the other plans that have been disapproved [on July 31] have already refiled [with the OIC]. I have no idea whether they have been in contact with the OIC or not. We are completely ready to refile ... and have been actually. [Emphasis added.]*

On the subject of whether or not the OIC was negotiating with other carriers and not the Company after July 31, in addition to the testimony of the Company discussed above, while not under oath, AnnaLisa Gellerman, counsel for the OIC, stated: Ms. Gellerman: *The Commissioner is taking the position that for those companies that did not request a hearing we would not accept any new filings, ... For those that requested a hearing, the commissioner has authorized some small changes ... (inaudible) ... Not with this company. ... If there is a meaningful opportunity – how far away from [approval the filing is] ... If you've been disapproved, you're done. July 31, everything is done. If you requested a hearing, and you are in the process of a hearing, we are using the potential of settlement negotiations to determine if there is anything that can be done for those companies that in the opinion of the OIC are very close to approval.* [Unsworn statement of Gellerman, counsel for OIC, presented during Day 3 of hearing at 5:00 p.m..]

Therefore, clearly evidence regarding whether the OIC was negotiating with other carriers after July 31 was presented by the Company and in a statement from OIC counsel, and most definitely not the undersigned. Further, this evidence is specifically identified in Finding No. 20 as the basis for finding that the OIC was negotiating with other carriers: *...the Company testified at hearing, and it was acknowledged by OIC counsel, and is therefore here found, that the OIC has in fact entertained communications, settlement negotiations and new/amended filings with other similarly situated carriers whose filings it disapproved on July 31 even though it has refused to allow any communications with Coordinated Care. [Testimony of Fathi.] [Finding of Fact No. 20.]*

2) Second, the OIC does not identify what "factual errors" it is referring to, it is not possible to review and consider this portion of the OIC's argument. To the extent there was evidence of settlement negotiations with other carriers presented by the Company and to some extent the OIC, this evidence had no bearing on whether the OIC's July 31 objections to the Company's July 25 filing were reasonable. To the extent this evidence were relevant at all it would be considered relative to whether the OIC's erred in its process of review and disapproval of the Company's July 25 filing [See Conclusion of Law No. 3] but in fact this evidence was given no weight and did not affect the Final Order in any way.

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3) Third, assuming that ER 408 applies to this proceeding by virtue of RCW 34.05.452(2) (which requires a presiding officer to refer to the Washington Rules of Evidence as guidelines for evidentiary rulings): in this Motion the OIC recognizes that ER 408 does permit evidence of settlement negotiations for limited purposes such as to prove bias, and for other reasons, but the OIC then incorrectly asserts that there was no claim of bias in this case. Contrary to the OIC's argument here, from even before commencement of the hearing the Company asserted that the OIC was treating it unfairly (i.e. in a biased manner) in the approval process and thereby made bias a significant issue in this case. [E.g., Prehearing Brief, pgs. 1-4; Testimony of Dr. Faithi; Testimony of Sarah Ross.] Even the OIC entertained bias as an issue in this case, presenting hours of evidence of how it had spent extra time and effort helping this particular Company in comparison to others. The issue regarding whether the OIC was treating the Company as being treated unfairly was also recognized in the Final Order at Finding of Fact No. 20, which states: *Coordinated Care argues that it is being treated unfairly in comparison with other carriers. [Coordinated Care Prehearing Brief; Testimony of Faithi.]*

More specifically, evidence that bias was a significant issue in this case were – whether or not they were proven at hearing - the Company specifically argued that the OIC was treating it unfairly in comparison to other carriers seeking to have their products approved for the Exchange [Company's Prehearing Brief, pgs. 2-4]: beginning in its Prehearing Brief filed prior to commencement of the hearing, Company asserted that the OIC had indicated it would rather deal with only commercial carriers for this year's Exchange and with Medicaid carriers (such as the Company) next year; that the OIC changed its cooperative attitude with the Company when the Company decided to build its own network and began rejecting submissions for overly technical reasons; that the OIC did not conduct a full analysis of the Company's submission until July 2013 despite the fact that it had a complete product to review beginning with the Company's June 2013 filing; that the OIC's approach to the Company differed from the OIC's treatment of the commercial carriers e.g. the OIC issued numerous objection letters to other carriers, e.g. the Company asserted that the OIC sent objection letters to Group Health in May, June, and July, and gave those carriers opportunities to correct their errors in order to assist them in submitting an acceptable plan for approval, yet the OIC sent only one set of objections to the Company in July many of which were vague or unclear [Ex. 53, OIC July 22 Objection Letter to form filing; Ex. 55, OIC July 17 objection letter to binder; Ex. 57, OIC objection letter to rate filing]; that throughout the process the OIC gave the Company conflicting instructions, e.g. re whether or not Children's Hospital must be included in its network; that other advice was vague or unclear and yet later on the Company was instructed not to contact Kreidler to ask questions, which made it more difficult and expensive for the Company to try to determine what the OIC's remaining concerns were and yet despite its efforts on July 31 the OIC disapproved the Company's entire filing and determined not only that it could not refile but that the OIC could not communicate with the Company at all, which left the Company no time to address any remaining concerns it might not have understood correctly (not having access to the OIC for some time); and after July 31 the OIC refused to communicate with the Company.

4) The OIC argues that the record does not support any findings that the OIC was

communicating with other carriers; presumably the OIC means findings that the OIC was communicating with other carriers after July 31, 2013. However, clearly the record supports such a finding. See Section 1) above concerning the Company's and the OIC's own statements that the OIC was communicating with other carriers after July 31, 2013. As stated above, however, the evidence presented by the Company and statements of the OIC that the OIC was communicating with other carriers after July 31 is not relevant to the issue in this proceeding regarding whether or not the Company's filings as written were in compliance with the ACA and state rules; while the Company's evidence and the OIC's statements might be relevant to whether the OIC erred in its review and disapproval which as above and as stated in Conclusion of Law No. 3 included some consideration of the review process, this evidence was given no weight and did not affect the Final Order in any way.

For the above four reasons, the OIC's argument is without merit.

**IV. (OIC's Argument No. 4 in support of its Motion for Reconsideration): The OIC argues that the Final Order contains Findings of Fact about communication between Coordinated Care and the OIC during the proceedings that are not supported by an objective evaluation of the record.**

This argument is duplicative of Argument No. 2 in the OIC's Motion, which is addressed in Section III above. However, toward the end of its Motion, the OIC lodges a host of assertions related to this argument. More specifically, the OIC states 1) that RCW 34.05.461 provides that a "presiding officer shall not base a finding exclusively on inadmissible evidence unless the presiding officer determines that doing so would not unduly abridge the parties' opportunities to confront witnesses and rebut evidence and the basis for this determination shall appear in the order." Then, the OIC goes on to state, incorrectly, that "the evidence presented by the Hearing Officer about settlement negotiations with other parties ... was not submitted by either party, but by the Hearing Officer herself....Coordinated Care was apparently unaware of the OIC's settlement discussions with other carriers until the Hearing Officer introduced the subject. The OIC could only object; it had no opportunity to confront the Hearing Officer as a witness...." In response, contrary to the OIC's assertions, the Company was very clearly aware that the OIC was in communication with other carriers when it refused to communicate with this company, and testified to its knowledge at hearing. [Testimony of Fathi; Testimony of Ross.]

The OIC further argues that the undersigned's decision "to not only consider, but inject, evidence of the OIC's settlement discussions in other proceedings as evidence 'calls the Hearing Officer's impartiality into question.'" The OIC then concludes that by presenting the evidence of the OIC's settlement negotiations, the Hearing Officer essentially made herself a material witness concerning disputed factual allegations and in doing so "has called into question her own partiality concerning this and every case involving the OIC's denial of a carrier's rate, form and binder filings." The OIC even goes on to argue that impartiality by a judge and improper

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testimony by a witness both constitute grounds for granting a CR 59 motion for retrial or reconsideration on the basis of irregularity in the proceeding, citing cases irrelevant to the situation at hand. The OIC then concludes this litany of rules which are either not applicable, or not based on fact, by arguing that "*because the Hearing Officer's presentation and admission of evidence of the OIC's settlement negotiations was improper under RCW 34.05.452(2), RCW 34.05.461, ER 408 ... , the Final Order should be reconsidered, omitting this improperly admitted information and the directives based upon it.*" In response, contrary to the OIC's assertions, once again, as discussed above, the Company argued in its Prehearing Brief that the OIC treated it unfairly in many ways specified therein, and at hearing presented evidence of these activities (whether or not they were found to have occurred), including the OIC's refusal to communicate with the Company post-July 31 and presented further evidence that after July 31 the OIC approved the plans of other carriers like the Company who had filed Demands for Hearing (and perhaps others) whose filings it had disapproved on July 31. [Testimony of Fathi; Statement of OIC counsel.]

In further response to the OIC's fourth set of arguments, as above, the parties agreed that the issue in this proceeding was *whether the OIC erred, on July 31, in disapproving the Company's July 25 filing.* From before the hearing in its Prehearing Brief, the Company argued that the OIC was treating it unfairly in the approval process, and at hearing presented evidence that the OIC was negotiating with other carriers. Bias was raised by the Company from the outset and was a significant issue in this proceeding. Therefore bias should have been, and was, considered by the undersigned in entering the Final Order; therefore even assuming ER 408 applies, ER 408 allows the presiding officer to consider evidence of settlement negotiations to show bias. Further, the Final Order certainly did not *rely exclusively on inadmissible evidence.* E.g., contrary to the OIC's assertions, the Company certainly knew, and testified to, the fact that the OIC was communicating after July 31 with other similarly situated carriers it had disapproved on July 31: Dr. Fathi testified he had seen on the internet that the OIC had approved other carriers' plans which he knew had been disapproved on July 31. [Testimony of Fathi; see also Testimony of Sara Ross.] Finally, statements of OIC counsel at hearing advised that it was selecting which carriers whose plans it disapproved on July 31 to negotiate with post-July 31 – and advised that those carriers did not include this Company. [Transcript of proceedings, at Day 3.]

**OIC'S ADDITIONAL CONCERNS ABOUT FINAL ORDER**

While these issues are related to the OIC's arguments above, and are repeated throughout the OIC's Motion, the fact should be addressed that the OIC has lodged at least four pages of serious assertions about the integrity of the Final Order and the Hearing Officer which cannot be ignored even when it is understood that the OIC chose to take just two days between the time it received the Final Order and the time it filed its Motion for Reconsideration. Specifically, the OIC asserts that the Final Order "*command[ed]*" and "*forced*" and "*compelled*" and "*coerced*" the OIC to approve the filings "*even though the filings were in violation of law*" and "*upon terms dictated by the Hearing Officer*" without authority to do so. The OIC asserts that "*The Final Order cites no*

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*authority ... which allows the Hearing Officer to refuse to rule on a matter, instead holding that matter open until a compulsory settlement, the terms of which are dictated by the Hearing Officer, has been reached."* The OIC asserts that the Final Order "change[d] a legal ruling as punishment for one of the parties' failure to cooperate with directives in an Order," and "set[s] the dangerous precedent that the OIC is now compelled to settle with any carrier who challenges the OIC's disapproval of their network, rate, form, or binder filings...the Final Order broadcasts to every health carrier ... that, by demanding a hearing on any disapproved filing, they can force the OIC to fix their contracts for them, ...." [Emphasis in original.] Further, the OIC asserts, incorrectly, that in the Final Order the Hearing Officer "decid[ed] to not only consider, but inject, evidence of the OIC's settlement discussions in other proceedings as evidence that the OIC mishandled Coordinated Care's filings" and thereby "made herself a material witness" and [citing the admittedly inapplicable CJC 2.11(a), 2.11(1), (2)(d) 2.6(B)] "called into question her own partiality concerning this and every case involving the OIC's denial of a carrier's rate, form, and binder filings" and implied that the Hearing Officer had "personal knowledge of facts" and/or was "likely to be a material witness in this proceeding" and further implies that the Hearing Officer should have disqualified herself for "bias, prejudice, interest..." under RCW 34.05.425(3) (even though this statute requires that the OIC - not the Hearing Officer - must act yet the OIC made no mention of these concerns either before or during the hearing and indeed not until it had received the Final Order). Finally, at the end of the OIC's four pages dedicated to this topic, the OIC postulates that the "OIC may be reading too much into the Final Order[.]"

In response, first, the OIC certainly has read too much into the Final Order, and a careful reading and consideration of it should respond to many of the OIC's concerns. Second, as discussed in detail above, the OIC is simply incorrect in its statement that evidence of the OIC's settlement negotiations with other carriers which was introduced by the Hearing Officer, not by either party when in fact the evidence was introduced by the Company, and to some extent the OIC, and no evidence was introduced by the Hearing Officer. Third, the Final Order can only be based on the evidence presented at hearing. The problems with the OIC's arguments and evidence are detailed above. It is not possible to enter the Findings and Conclusions which the OIC suggests should have been made when the arguments made by the OIC were not consistent with its prior actions and statements to the Company, were on occasion contradictory even at hearing or at best unclear. It is also not possible to enter the Findings and Conclusions which the OIC suggests should have been made when the evidence presented by the OIC at hearing was on some occasions contrary to what it now argues, and was inconsistent over time even during the course of the hearing; and on other occasions was either nonexistent or insufficient. In addition, as also discussed above in more detail, the OIC's presentation of evidence was limited by the fact that two of the OIC's three witnesses had not even been involved in the filing process with this or perhaps any other carrier submitting filings for the Exchange. In addition, one admitted at hearing he had not even read the Company's entire filings, and the other admitted she was new to her position and not familiar with the ACA.

For all of the reasons discussed above, the OIC has failed to show any basis upon which reconsideration should be granted.

CONCLUSION

Based upon the above authorities and analysis, the OIC has not persuaded the undersigned that there are any issues of fact or law that warrant reconsideration of the Findings of Fact, Conclusions of Law and Final Order entered by the undersigned on September 3, 2013. Further, the OIC has not persuaded the undersigned that she committed error, manifest or otherwise, in entering her Findings of Fact, Conclusions of Law and Final Order in this matter. Therefore, the OIC has not made the requisite showing for reconsideration pursuant to state and federal rules and case law, and thus the OIC's Motion for Reconsideration should be denied.

ORDER

On the basis of the foregoing,

**IT IS HEREBY ORDERED** that the Insurance Commissioner's Motion for Reconsideration is **DENIED**.

ENTERED at Tumwater, Washington, this 15<sup>th</sup> day of November, 2013, pursuant to Title 34 RCW and specifically RCW 34.05.470; Title 48 RCW; and regulations pursuant thereto.

  
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PATRICIA D. PETERSEN  
Chief Presiding Officer

Pursuant to RCW 34.05.461(3), the parties are advised that, pursuant to RCW 34.05.514 and 34.05.542, this order may be appealed to Superior Court by, within 30 days after date of service (date of mailing) of this order, 1) filing a petition in the Superior Court, at the petitioner's option, for (a) Thurston County or (b) the county of the petitioner's residence or principal place of business; and 2) delivery of a copy of the petition to the Office of the Insurance Commissioner; and 3) depositing copies of the petition upon all other parties of record and the Office of the Attorney General.

Declaration of Mailing

I declare under penalty of perjury under the laws of the State of Washington that on the date listed below, I mailed or caused delivery through normal office mailing custom, a true copy of this document to the above identified individuals at their addresses listed above.

DATED this 18<sup>th</sup> day of November 2013.

  
\_\_\_\_\_  
KELLY A. CAIRNS