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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

SEATTLE CHILDREN'S  
HOSPITAL'S RESPONSE TO OFFICE  
OF THE INSURANCE  
COMMISSIONER, BRIDGESPAN  
HEALTH COMPANY AND  
PREMERA BLUE CROSS' JOINT  
MOTION IN LIMINE RE: HOSPITAL  
ADMINISTRATIVE EXPENSE

I. SUMMARY

The Joint Motion seeking to exclude from this hearing all evidence regarding "the alleged administrative expense associated with single case agreements" should be denied for the following reasons:

(1) Evidence regarding SCH's administrative expenses relating to the Premera/LifeWise and BridgeSpan QHPs is relevant insofar as SCH is required, in order to proceed under RCW 48.04.010, to establish that it is "aggrieved" by the Commissioner's action.

(2) The motion's assertion that any consideration of provider administrative expenses results in unnecessary comparative consideration of provider reimbursement conflicts with the ACA and state law requirements to consider whether a provider is "willing to accept the generally applicable payment rates" of the plan, or under state law, willing "to contract with the carrier under reasonable terms and conditions."

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(3) The expense to providers from managing care for out-of-network patients and obtaining reimbursement for those services is directly relevant to the purposes of the network adequacy requirements.

(4) The motion is untimely. Under the Pre-Hearing Order in this matter, motion practice is governed by KCLR (b)(4)(a), which requires six court days notice for non-dispositive motions, and allows 3.5 court days for response. In order to disrupt SCH's hearing preparations, intervenors purposefully sat on this and their other motions in limine until after the August 8 deadline for such filings. For this reason alone, the motion should be denied.

## II. ARGUMENT

### A. **Evidence of Harms to SCH Patients and SCH Is Relevant to RCW 48.04.010 Standing.**

SCH has standing to pursue this action because SCH and its patients have been "aggrieved by any act ... of the commissioner." RCW 48.04.010. The issue of standing, already extensively briefed in the hearing briefs and earlier, remains for resolution at the hearing. SCH can and must present evidence regarding how it and its patients have been "aggrieved." One of the ways in which SCH has been aggrieved is by the administrative expenses it has incurred because of the new costs relating to the BLEs and single case agreements for these QHPs.

### B. **The Motion Ignores ACA and State Law Requirements re: Consideration of Provider Willingness to Contract at "Generally Accepted Rates" or "Reasonable Terms."**

The motion asserts that any consideration of SCH's administrative expenses would result in comparative consideration of its reimbursement rates, which it asserts would be "unproductive." To the contrary, reimbursement rates are a factor in determining compliance with network adequacy requirements. The ACA's ECP requirement is subject to exception only where ECPs are not available or an available ECP is not "willing to accept the generally applicable payment rates" of the plan.<sup>1</sup> State network adequacy requirements required

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<sup>1</sup> 42 U.S.C. §18031(c)(2).

consideration of whether a provider was, willing “to contract with the carrier under reasonable terms and conditions.”<sup>2</sup> The evidence will demonstrate that although SCH offered to contract with the intervenors at their existing commercial rates, the intervenors ignored the offers and simply informed SCH that it was not in the QHP networks. The consequences of the OIC’s admitted failure to consider this information is not irrelevant.

**C. Burden and Expenses Relating to Out-of-Network Care Demonstrate the Inadequacy of Intervenors’ Networks.**

The motion asserts that provider financial burdens related to out-of-network care are irrelevant. To the contrary, they demonstrate the purpose of the network adequacy requirements. Unlike other types of insurance products (such as disability insurance<sup>3</sup>) relying solely on post-care indemnity, and for which minimum financial security requirements must be met,<sup>4</sup> HCSC plans are exempt from such requirements provided that they establish adequate networks of contracted providers.<sup>5</sup> State network adequacy requirements ensure that HCSCs have made adequate arrangements to service the health needs of its insureds in the absence of the financial security assurances made by other types of insurers. State review of an HCSC’s provider contracts<sup>6</sup> is designed to protect the enrollee and the providers in ensuring that those contracts are fairly drafted and negotiated in advance, since negotiations at or after the time of treatment inevitably causes delay in either patient care or in compensation to the provider. The administrative expense injury resulting to SCH from the absence of provider contracts reflect exactly these harms that the network rules were designed to prevent.

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<sup>2</sup> Former WAC 284-43-200.

<sup>3</sup> RCW 48.20.

<sup>4</sup> RCW 48.13.

<sup>5</sup> RCW 48.44.030.

<sup>6</sup> RCW 48.43.730(2)(a).

**D. The Motion Is Untimely.**

As explained above, this motion could and should have been submitted by August 8<sup>th</sup>, which would have allowed SCH the appropriate number of days to prepare a response. Intervenors have not provided the slightest excuse for this act of gamesmanship.

DATED this 14<sup>th</sup> day of August, 2014.

BENNETT BIGELOW & LEEDOM, P.S.

By 

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**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:

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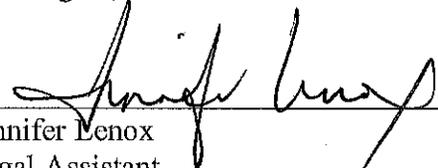
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I declare under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

Executed at Seattle, Washington, this 14<sup>th</sup> day of August, 2014.

  
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Jennifer Lenox  
Legal Assistant

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