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STATE OF WASHINGTON
OFFICE OF THE INSURANCE COMMISSIONER

In re	DOCKET NO. 13-0293
Seattle Children's Hospital's Appeal of OIC's Approvals of HBE Plan Filings	JOINT MOTION IN LIMINE OF PREMERA BLUE CROSS, OFFICE OF INSURANCE COMMISSIONER, AND BRIDGESPAN HEALTH COMPANY REGARDING POST-APPROVAL MATTERS

I. INTRODUCTION

This proceeding concerns a decision—the OIC's July 31, 2013 approval of the Washington Health Benefit Exchange plans of Premera Blue Cross and BridgeSpan Health Company—and the process leading up to that decision. What happened after July 31, 2013, is irrelevant and, under Washington law and the Affordable Care Act ("ACA"), should be excluded from the evidence.

II. BACKGROUND

Pursuant to the ACA, and the Washington state statutory scheme enacted pursuant to the ACA, the Washington Health Benefit Exchange ("HBE" or "Exchange") relies exclusively on private health carriers (also known as issuers) such as Premera to provide healthcare insurance to Washington citizens. This same scheme requires the OIC (Office of the Insurance Commissioner) to evaluate and approve health carriers to participate in the HBE.

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Under the ACA, Washington has established its own marketplace for residents to apply for and purchase HBE health insurance contracts. *See* 42 U.S.C. § 18031. The OIC is charged by the ACA and state law to establish Washington's marketplace, the HBE; to determine which health plans are qualified to participate in the HBE; and to ascertain that the content of all health plans offered through the HBE meet strict benefit and quality standards. *See* RCW 43.71.*005, et seq.*

On July 31, 2013, the OIC, pursuant to Washington law and the ACA, approved the HBE plans of Premera Blue Cross ("Premera") and BridgeSpan Health Company ("BridgeSpan"). Seattle Children's Hospital ("SCH") is attempting to introduce testimony and documentary evidence concerning a number of matters that post-date the OIC's decision. But these matters are irrelevant and may not be admitted into evidence in these proceedings.

Network adequacy requirements exist solely for the benefit of health plan enrollees. Accordingly, the OIC assesses network adequacy from the enrollee-consumer's perspective and approves a health plan if it provides access to covered services at in-network cost.

> Q When the OIC is reviewing a plan for approval for the exchange, why does it review network adequacy as part of its review?
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> A Because the contracts that have network access to them are guaranteeing services at an in network cost share rate, so we look to make sure that there are (sic) access to covered services -- well, access to medically necessary covered services at the in network cost share.
>
> Q Does it matter in the OIC's review whether for the purposes of network adequacy whether the services are available in network or out of network?
>
> A It matters that we look at it from the consumer perspective and that the consumer can get access to services at in network cost share.

OIC Healthcare Consumer Access Manager Jennifer Kreitler deposition, 56:16 – 57:5[1].

[1] In this proceeding the OIC's interpretation of the applicable law will be conclusive. With respect to statutes, "where the agency's interpretation of a statute is at least as plausible as competing ones, there is little, if any, reason not to defer to its construction." *Good Samaritan Hosp. v. Shalala*, 508 U.S. 402, 417-18, 113 S. Ct. 2151, 2161, 124 L. Ed. 2d 368

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Premera and BridgeSpan ensure enrollee access to pre-authorized specialty services at "in network cost share" through 1) contracts with participating providers whereby the providers agree to accept agreed reimbursement rates and bill patients only for the coinsurance (deductible and co-pay) provided for in their contract with the health carrier; 2) benefit level exception processes, and 3) single case agreements with non-contracted providers. The benefit level exception process and single case agreements enable Exchange plan members to obtain treatment at Children's or other providers outside the Exchange network pursuant at an in-network benefit level. In return for the agreed upon reimbursement rate, the out of network provider has agreed in the existing contract (in the case of Premera's benefit level exception process) or agrees in the single case agreements not to bill the patient beyond what the patient would pay for in-network care. This is authorized by WAC 284-43-200 (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.*** [Emphasis added.]

SCH intends to offer evidence and argument concerning the alleged administrative expense borne by SCH associated with benefit level exceptions and single case agreements. Although SCH's Demand seeks relief related to the OIC's decision to approve Premera's and BridgeSpan's plans for the Exchange—an inquiry that is constrained to a period of time ending July 31, 2013, when the OIC was considering these networks—SCH has attempted to

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(1993). With respect to regulations, "[w]hen the meaning of regulatory language is ambiguous, the agency's interpretation of the regulation controls so long as it is 'reasonable,' that is, so long as the interpretation sensibly conforms to the purpose and wording of the regulations." *Lezama-Garcia v. Holder*, 666 F.3d 518, 525 (9th Cir. 2011).

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expand this case into an inquiry of whether these Exchange plans are effectively providing care to Premera and BridgeSpan members. This is irrelevant to the question before this tribunal.

SCH must live with its own demand for relief. SCH's Demand seeks relief related to the OIC's decision to approve Premera's and BridgeSpan's plans for the Exchange—an inquiry that is constrained to a period of time ending July 31, 2013, when the OIC was considering these networks. The OIC's decision to certify these plans is based on whether the plans on July 31, 2013 satisfied the applicable provisions of Washington law and the Affordable Care Act. Thus, any inquiry into the status of these plans post-certification is irrelevant.

Irrelevant evidence that Children's intends to offer includes the testimony of SCH witnesses Jenni Clark and Alexandra Szablya, two Exchange consumers, who are testifying only to events that occurred following the OIC's approval of Premera's network.[2] Likewise, any evidence regarding the communications between SCH and the health plans *after* certification by the OIC, evidence regarding the administrative burden on SCH to process pre-authorization claims, and the general effectiveness of these plans in 2014 is all irrelevant. It is important that this tribunal limit its inquiry to the relief that SCH sought in its demand and available under the applicable law—i.e., the inquiry should be limited to whether the OIC properly approved the networks of Premera and BridgeSpan.

III. LEGAL ARGUMENT

A. The Presiding Officer Has the Authority to Grant This Motion in Limine.

A pre-trial motion in limine may be brought to decide certain evidentiary issues before they arise at trial. *Fienmore v. Drake Construction Co.*, 87 Wn.2d 85, 549 P.2d 483 (1976); *State v. Smith*, 189 Wn. 442, 65 P.2d 966 (1937). The Washington Administrative

[2] These consumers will testify that although Premera granted their BLE requests, they did not like the experience and feel that they should not be required to seek pre-approval before accessing services at SCH.

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Procedure Act provides that a presiding officer shall exclude evidence that is excludable on constitutional or statutory grounds. RCW 34.05.452(1).

B. Post-Approval Evidence Should Be Excluded As Irrelevant and Prejudicial.

Superior Court Local Rules for King County, Washington, govern non-dispositive motions in this proceeding. Order on Pre-Hearing Conference at 3. This includes the Washington Rules of Evidence.

Washington Rule of Evidence Rule 402 provides that "[e]vidence which is not relevant is not admissible." Evidence Rule 401 defines "relevant evidence" as evidence "having any tendency to make the existence of any fact that is of consequence to the determination of the action more probable or less probable than it would be without the evidence." Additionally, under Evidence Rule 403, relevant evidence may nonetheless be excluded if its "probative value is substantially outweighed by the danger of unfair prejudice."

SCH's proffered evidence and argument concerning provider administration should be excluded on three bases. First, the issue in this matter is whether the OIC complied with state and federal law in approving the Premera and BridgeSpan Exchange health plans. Nowhere in state or federal regulations is provider administrative burdens included as a criterion or consideration in the regulator's assessment of network adequacy. The OIC has concluded that Premera's networks are adequate without Children's, because Premera's members receive any medically necessary services at Children's as an in-network benefit if that is the best option for the member. Indeed, because there are really no material factual issues joined in this proceeding, as a matter of law, all doubts must be resolved in favor of the OIC's approval of Premera's network. With respect to statutes, "where the agency's interpretation of a statute is at least as plausible as competing ones, there is little, if any, reason not to defer to its construction." *Good Samaritan Hosp. v. Shalala*, 508 U.S. 402, 417-18, 113 S. Ct. 2151, 2161, 124 L. Ed. 2d 368 (1993). With respect to regulations,

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"[w]hen the meaning of regulatory language is ambiguous, the agency's interpretation of the regulation controls so long as it is 'reasonable,' that is, so long as the interpretation sensibly conforms to the purpose and wording of the regulations." *Lezama-Garcia v. Holder*, 666 F.3d 518, 525 (9th Cir. 2011).

Second, any alleged administrative expense could not have been incurred until January 2014, i.e., it was not known to the regulator in July 2013.

Third, if the expense associated with benefit level exceptions and single case agreements is to be considered, the increased reimbursement received by the hospital pursuant to such agreements as compared with network reimbursement rates must then be considered—but to what end? This tribunal is not empowered to award damages and SCH does not seek damages. Ultimately, this is an unproductive inquiry into irrelevant matters that will unnecessarily consume hearing time.

The other evidence of post-July-2013 matters that SCH seeks to admit is likewise irrelevant and thus inadmissible. For example, the effectiveness of benefit level exceptions and single case agreements, Ms. Clark's and Ms. Szablya's proffered testimony concerning events that occurred after approval, communications between SCH and the health plans that postdate certification, and the general effectiveness of the plans are all irrelevant to any inquiry into the OIC's decision to approve Premera's and BridgeSpan's plans.

IV. CONCLUSION

For the foregoing reasons, the testimony and documentary evidence SCH seeks to admit concerning matters that occurred after July 2013 should be excluded from this proceeding.

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CERTIFICATE OF SERVICE

I, Ian Rountree, hereby certify under penalty of perjury of the laws of the State of Washington that on August 11, 2014, I caused to be served a copy of the attached document to the following person(s) in the manner indicated below at the following address(es):

OIC HEARINGS UNIT Office of the Insurance Commissioner 5000 Capitol Boulevard Tumwater, WA 98501 Email: kellyc@oic.wa.gov	**Seattle Children's Hospital** Michael Madden Bennett Bigelow & Leedom, P.S. 601 Union Street, Suite 1500 Seattle, WA 98101 Email: mmadden@bbllaw.com
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