July 15, 2022

Ms. Barb Jones
Washington State Office of the Insurance Commissioner
P.O. Box 40258
Olympia, WA 98504
Submitted via e-mail to: rulescoordinator@oic.wa.gov

RE: R 2022-05 Cost-sharing for prescription drugs

Dear Ms. Jones,

On behalf of Cambia Health Solutions family of insurance companies ("Cambia"), including Regence BlueShield, Asuris Northwest Health, and BridgeSpan Health Company, thank you for the opportunity to provide comments on the prepublication draft of cost-sharing for prescription drugs rules. We look forward to partnering with the Office of the Insurance Commissioner (OIC) to ensure effective implementation of the requirements in SSB 5610 from the 2022 legislative session. Our internal subject matter experts have reviewed the legislation itself and the OIC's prepublication draft and would like to offer the following comments for your consideration.

Our overall request is to align the rule language as closely as possible to the language in SSB 5610. SSB 5610 was highly negotiated, and we believe it is important that the intent and nuance not get lost in translation through differing regulatory language. In line with that recommendation, our comments will focus on proposed revisions to the prepublication draft language to ensure the rules do not create additional requirements that were not contemplated during the legislative process.

Please see our suggested edits that pertain to the following topics within the prepublication draft.

Calculating enrollee cost-sharing and out-of-pocket maximums

We recommend the following revisions to WAC 284-43-5080(5)(a) to ensure consistency with SSB 5610 and throughout the draft rules:

> (a) For the purposes of this subsection, **any** cost sharing **amount paid directly by or on behalf of the enrollee by another person for a covered prescription drug** ~~or out-of-pocket amounts include payments from all sources as though it was paid by the enrollee directly and~~ must be applied in full toward the enrollee's applicable cost-sharing as defined in WAC 284-43-0160 or out-of-pocket maximum as defined in RCW 48.43.005 consistent with RCW 48.43.xxx (Substitute Senate Bill No. 5610, chapter 228, Laws 2022).

Application to High Deductible Health Plans

Sec. 1(5) of SSB 5610 states "This section does not apply to a qualifying health plan for a health savings account to the extent necessary to preserve the enrollee's ability to claim tax exempt contributions and withdrawals from the enrollee's health savings account under internal revenue service laws, regulations, and guidance." To preserve an enrollee's health savings account (HSA) eligibility, high-deducible health plans can only cover preventive services without applying the deductible; all other services must meet the health plan's deductible first. The proposed language in WAC 284-43-5080(5)(c) goes beyond what the legislation requires by mandating the individual and family deductibles be the minimum deductibles set by the IRS. The language in Sec. 1(5) of SSB 5610 was a specific element of negotiations on the bill and we do not believe it should be changed through the rulemaking process. The intent was to apply the cost-sharing requirements in SSB 5610 to a qualified high deductible health plan *after* the enrollee meets their health plan's deductible. We respectfully request the OIC incorporate the following changes to WAC 284-43-5080(5)(c):

> (c) ~~A qualifying health plan for a health savings account (HSA-qualifying plan) is not subject to the requirements under~~ RCW 48.43.xxx (Substitute Senate Bill No. 5610, chapter 228, Laws 2022) **does not apply to a qualifying health plan for a health savings account to the extent** ~~An HSA-qualifying plan may apply a deductible to coverage of prescription drugs only at a minimum level~~ necessary to preserve the enrollee's ability to claim tax exempt contributions and withdrawals from the enrollee's health savings account under Federal Internal Revenue Service laws and regulations. ~~The individual and family deductibles applied to prescription drugs under an HSA-qualifying plan must be the minimum deductibles set by the Federal Internal Revenue Service for a plan to be an HSA-qualifying plan under Federal Internal Revenue Service laws, regulations, and guidance.~~

Certification of coverage disclosures:

WAC 284-43-5080(5)(d) prescribes information that health plans must include in an enrollee's certificate of coverage. Health plans have already filed plan year 2023 forms with the OIC, which were required to comply with SSB 5610. We would appreciate the flexibility to disclose the necessary information to members in an easy to understand manner and in a way that would not require substantial revisions to our filings. We believe the language in this subsection should clarify that carriers are not required to insert the exact language from the regulation or legislation into member booklets. If the OIC wants to keep the detailed requirements from the legislation that are outlined in this subsection ((5)(d)(i)-(iii)), we would recommend they are moved under subsection (5)(a) and not be specific to the certificate of coverage.

Additionally, we are concerned that the language proposed in WAC 284-43-5080(5)(d)(iv) creates a new requirement for prescription drug cost sharing that was not contemplated during the legislative session. Sec. 1(1)(a)(iii) in SSB 5610 requires that a health plan continue to apply the cost-sharing requirements outlined in the legislation while an enrollee is utilizing the prescription drug exception request process under RCW 48.43.420, including any appeal of a denial of an exception request. This requirement is clear within the statute and it also made clear in WAC 284-43-5080(5)(b) of the prepublication draft. We

believe it is above the scope of SSB 5610 to require the cost-sharing requirements also apply throughout the adverse benefit determination process under WAC 284-43-3000 through 284-43-3190. That process includes determinations that are outside of the drug exception request process, and it is not necessary to reference the adverse benefit determination process to ensure that the cost-sharing requirements from SB 5610 apply throughout the appeal process for a drug exception request. We believe the proposed language in WAC 284-43-5080(5)(d)(iv) will create more questions and confusion regarding when health plans must count payments towards cost-sharing and out-of-pocket maximums.

For the above reasons, we recommend the following revisions to WAC 284-43-5080(5)(d):

> (d) For nongrandfathered health plans with a prescription drug benefit, the health carrier must disclose ~~to the enrollee the following information~~ in the enrollee's certificate of coverage: ~~A statement~~ that any **cost-sharing** amounts paid by the enrollee directly for a prescription drug, or paid on behalf of the enrollee by another person for a prescription drug, including payments made through application of a manufacturer drug coupon or other manufacturer discount, must be counted towards an enrollee's contribution to any applicable deductible, copayment, coinsurance, or out-of-pocket maximum**, consistent with RCW 48.43.xxx (Substitute Senate Bill No. 5610, chapter 228, Laws 2022).**~~, if any of the following apply:~~
>
> ~~(i) The prescription drug has no generic equivalent or a therapeutic equivalent that is preferred under the health plan's formulary;~~
>
> ~~(ii) The prescription drug has a generic equivalent or therapeutic equivalent that is preferred under the health plan's formulary, but the enrollee has otherwise obtained access to the prescription drug through prior authorization, step therapy or fail-first protocols, or the carrier's prescription drug exception request process under RCW 48.43.420;~~
>
> ~~(iii) Coverage for the prescription drug has been requested under RCW 48.43.420 and the decision to approve or deny the exception request has not been made and communicated to the carrier; or~~
>
> ~~(iv) Coverage for the branded prescription drug is being reviewed through the adverse benefit determination process under WAC 284-43-3000 through 284-43-3190 and no final and binding determination has been made and communicated to the carrier~~

Thank you for considering our comments. Please let me know if you would like to discuss any of our feedback further. I can be reached at Jane.Douthit@Regence.com or (206) 332-5212.

Sincerely,

Jane Douthit
Cambia Health Solutions
Sr. Public & Regulatory Affairs Specialist