PacificSource

September 10, 2020

Ms. Mandy Weeks-Green
Policy Analyst, Office of the Insurance Commissioner
P.O. Box 40264
Olympia WA 98504

Re: R2020-04 Stakeholder draft (Benefit manager regulations)

Dear Mandy:

Thank you for the opportunity to submit comments on the benefit manager regulations stakeholder draft. The stakeholder process is valuable, and we appreciate being able to help refine the regulations before the CR102 phase of the rulemaking. Our comments are organized in order, by each section, for ease of reference.

Definitions

- WAC 284-180-130 (16) – to avoid confusion with chapter 18.64 RCW, which references pharmacy managers in the context of those managing a pharmacy, we suggest inserting the word "pharmacy benefit manager in RCW xxx."
- WAC 284-180-130 (18) – similarly, the statutory reference is to "radiology benefit manager" rather than radiology manager. We suggest inserting the additional word so that the reference is accurate.

Registration & Renewal Timeline

- WAC 284-180-220 (Registration): We suggest clarifying the language in this section. If the regulation is effective beginning 1/1/2022, and registration is submitted and approved prior to that date, the fiscal year ends 6/30/2022. Is the initial registration only good for six months, and then must be renewed during the first year by March 1, 2022? Is the renewal then required, or will the first year's registration period last through 6/30/2023?
- WAC 284-180-230 (2) (Renewal): please clarify how the renewal works: in the prior section, benefit managers aren't permitted to do business without an approved registration, which must be accomplished by the end of the fiscal year (6/30). In this section, the proposed regulation states that the renewal is due March 1, and the fee must be paid by July 15.

PacificSource Health Plans | 1100 "A" Street | Suite 200 | Tacoma WA 98401

But (3) of this section states that the application isn't complete until the correct fee is received, which per (2) could be after 6/30. Since the Commissioner states the fee will be calculated and an invoice sent on 6/1, that leaves a very short window to submit and finalize the application by 6/30. Does the OIC plan to require the HCBM to suspend operations for the period of time between 6/31 and when the renewal is considered complete and then is approved? This would disrupt member access to services, and make contracting and claims processing difficult.

It might be clearer to revise -220 and -230, and to include a reference to the ongoing requirement for PBMs to be registered until SB 5601 takes effect. Here is one suggestion that retains the requirements in the stakeholder draft:

WAC 284-180-220:

(1) Beginning, January 1, 2017, through December 31, 2021, ~~and thereafter,~~ to conduct business in this state, pharmacy benefit managers must register with the commissioner and must annually renew the registration.

(2) **Beginning January 1, 2022, and thereafter, to conduct business in this state, health care benefit managers, including pharmacy benefit managers, must have an approved registration with the commissioner, which must be renewed annually following the requirements set forth in WAC 284-180-230.**

(~~2~~ **3**) **Registration and renewal of registration must be accomplished using the commissioner's electronic system, which is available at www.insurance.wa.gov.** ~~Pharmacy benefit managers must register using the commissioner's electronic system, which is available at www.insurance.wa.gov.~~

(a) A complete application consists of the complete registration form, supporting documentation required by the commissioner and payment of the correct registration fee.

(b) The commissioner will calculate the fee and provide the applicant with an invoice for the initial registration.

(3 4) **For health care benefit managers registered during calendar year 2022, the initial registration is valid until June 30, 2023.**

WAC 284-180-230 (Renewal)

(1) Not later than March 1, 2023 and on March 1 every year thereafter, health care benefit managers must renew their registration. Renewed registrations take effect on July 1 and remain in effect until June 30 of the following year.

(2) Health care benefit managers must pay their renewal fee, and submit their registration renewal material through the commissioner's electronic system, which is available at www.insurance.wa.gov.

a. **The registration renewal form must include all information required on the form, and a statement of the health care benefit manager's Washington state annual gross health care benefit manager business income for the previous calendar year.**
b. **The commissioner will calculate the health care benefit manager's renewal fee for the upcoming registration period and post the invoice to the commissioner's electronic system not later than May 1.**
c. **Upon receipt of the renewal fee and review of the renewal materials, the commissioner will notify the health care benefit manager if the renewal is approved or denied**. [Is this also through the OIC electronic communication system?]

(3) **Failure to submit a registration renewal materials and pay the invoiced renewal fee may result in delayed renewal or non-renewal. Health care benefit managers providing services without an approved renewed registration are subject to penalties or sanctions under chapter 48.04 RCW.**

Records Retention

- WAC 284-180-310 (1) (b) (records) is inconsistent with the OIC's record's retention schedule in requiring registration and renewal materials to be retained for seven years. We suggest harmonizing the retention requirement to mirror the OIC's for licensing/ registration of records materials, and limiting the period to six years.

Notices

- WAC 284-180-330 (Notices):

    - The proposed regulation directs carriers to provide notice of all health benefit managers in a carrier's policy or member handbook, and also requires website posting. This requirement could be better aligned with carrier operations and current member communication practices.

      For example, Member handbooks are primarily provided electronically, with paper copies available on request. Posting to a separate webpage is redundant, and may result in confusion; our operations team suggested requiring a carrier to make the benefit manager information available electronically so that a member can easily access the information. Our operational preference is placement in the member handbook, which we update regularly if information changes. For benefit managers, we will also update our electronic provider manual to reflect a benefit manager and its services.

We suggest modifying the requirement that the enrollee must receive the notice in writing similar to the provisions permitting electronic notification of appeal rights (WAC 284-43-3090) or discontinuation of a plan (WAC 284-43-0290).

Contract Filing –Required Portal

- WAC 284-180-405 (contract Filings – definitions) (4) (a) there is either an extra word, or a missing phrase or citation in this subsection. Does the phrase "as defined in" need to be deleted?
- WAC 284-180-410 (purpose): (2) we recommend spelling out HCSC, HMOs and adding term "insurers" following disability.
- WAC 284-180-420 (SERFF): given the incorporation by reference of requirements, we ask that the Commissioner add a section stating that the Commissioner will provide direct notice to carriers and health benefit managers of intended changes to either Manual not less than 20 business days before the change becomes effective.

Carrier and PBM Contract Review Process

- WAC 284-180-430 (rejection): Use of the word "rejection" in this section creates ambiguity. We ask that the Commissioner clarify or distinguish the concept of "rejection" from "disapproval." Does the rejection option only occur at the initial filing or is rejection the culmination of the review process within SERFF?
- WAC 284-180-435 (filing authorization) and WAC 284-180-440: if the SERFF review process proceeds in relation to the same document filed by both a benefit manager and the carrier, how will the changes made in response to an objection by one be incorporated in to the other review process? May a carrier delegate its filing authorization to the health care benefit manager (or vice versa)?
- WAC 284-180-455 (carrier filings):
    - (4) We ask that the last 2 sentences in this subsection be split out into their own (5), unless the deeming is only meant to apply to value based compensation agreements with health benefit managers.
    - (5) appears to conflate the concept of a benefit manager and a provider. The payment to a participating provider would not be governed by the compensation paid to the benefit manager by the carrier. If the issue this is trying to address is provider support for whether an enrollee's plan requires interaction with a benefit manager, we suggest directing the carrier to ensure that information is readily available. If this section is concerned only with subcontracted networks, we recommend addressing the issue in the context of chapter 284-170, which deals with provider contracts, and including the relevant citation here for clarity.
    - The use and file requirement directly conflicts with the file prior to use requirements applicable to provider contracts. Please provide clear guidance

about which standard applies for those unique types of benefit managers who manage a sub-network of providers.

Thank you again for the opportunity to provide comments. Don't hesitate to reach out if you have any questions.

Sincerely,

Meg L Jones

Meg L. Jones
Director, Government Relations
PacificSource Health Plans
Meg.jones@pacificsource.com