PCMA

September 15, 2020

Mandy Weeks-Green
Office of Insurance Commissioner
Washington State
Rules Coordinator

Sent via email: rulescoordinator@oic.wa.gov

Re: Comments on R 2020-04 Health care benefit managers (HCBM) – Stakeholder draft August 24, 2020

Dear Rule Coordinator Weeks-Green:

On behalf of the Pharmaceutical Care Management Association (PCMA), thank you for the opportunity to respond to OIC's proposed rule implementing Senate Bill 5601 from the 2020 legislative session.

PCMA is the national trade association representing America's Pharmacy Benefit Managers (PBMs), which administer prescription drug plans for more than 266 million Americans with health coverage provided through Fortune 500 employers, health insurance plans, labor unions, and Medicare Part D. PBMs are engaged by clients including health insurers, government agencies, unions, school districts, and large and small employers, to manage pharmacy benefits pursuant to health insurance benefits and contracts. The work of PBMs are during the current COVID-19 crisis is emblematic of the work they do every day to help ensure patients have access to the right medicine at the right time.

We appreciate the OIC's help and guidance as PBMs comply within a new regulatory framework. It is our understanding based on the discussion during the stakeholder call that PBMs will be newly registered as a HCBM when these rules take effect. We recognize that the OIC is very familiar and adept at maintaining and protecting confidential and proprietary information received while performing its myriad regulatory functions. As noted on the September 9th stakeholder call, during the 2020 legislative session legislators and stakeholders actively engaged in discussions regarding contract submission and protections from public disclosure for submitted confidential and proprietary contracts. The legislature specifically included provisions in SB5601 exempting contracts filed with the OIC by HCBMs from public disclosure. The contract submission process and protections of such is a substantial component of the new regulatory framework for HCBM in Washington. We respectfully request consideration of referencing the public disclosure exceptions OIC operates under in WAC 284-180. We defer to the OIC as to whether this should be reiterated in regulation.

We offer the following comments and suggested changes to the stakeholder draft:

WAC 284-180-110
Purpose
We offer the following change in red to clarity that health care benefit managers are required to comply with provisions that are applicable to them. Some provisions in the chapter relate to carriers and are not applicable to health care benefit managers.

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(2) Health care benefit managers are responsible for compliance with the provisions of this chapter that are applicable and are responsible for the compliance of any person or organization acting on behalf of or at the direction of the health care benefit manager, or acting pursuant to health care benefit manager standards or requirements.

WAC 284-180-220
Health Care Benefit Manager Registration
We appreciate OIC staff confirming during the September 9 stakeholder call that PBMs will be considered newly registered as a HCBM when these rules go into effect and can otherwise continue to operate under existing PBM registration rules until that time.

WAC 284-180-230
Health Care Benefit Manager Renewal
We appreciate the OIC addressing the uniform or consistent application of Washington-state annual gross health care benefit manager business income for the previous calendar year to support calculating renewal fees across all benefit managers on the September 9th stakeholder call. We request the OIC ensures any financial measurement that registration renewal fees are based upon are reportable by all HCBM to support equitable application of renewal fees to all HCBM. We ask OIC to consider identifying a specific document(s) it will rely on to determine renewal fees – e.g., financial statements, 10K filing, etc.

In subsection (2)(a), please add in "1" after March to indicate the date by which a renewal must be submitted.

Subsection 5 states HCBM will receive notice of renewal application approval. We respectfully request the following change to ensure HCBM receive notice of incomplete applications, denials, as well as approvals of renewal applications.

(5) The health care benefit manger will receive notice of the status ~~approval~~ of the renewal application from the commissioner in a timely manner.

WAC 284-180-240
Providing and updating registration information
We request consistent use of the term "health care benefit manager" throughout the rule rather than use of an alternate term of "benefit manager."

We are concerned about the usefulness of providing information on non-active licenses. We believe the requested changes below will address the need to ensure the OIC obtains relevant and substantive information to conduct appropriate registration oversight.

(1)(d) ~~Other~~ Active business licenses that the benefit manager ~~has held~~ currently holds. ~~and those that are active~~

(1)(h) Identify if the health care benefit manager has been required to pay fines or penalties. Additionally, identify if the health care benefit manager has been suspended, found to have violated state law as determined by the judgment of a court of competent jurisdiction, ~~committed any violations in this or any state~~ or been the subject of a consent order from a department of insurance or other state agency.

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We request OIC specify which "business licenses" under (1)(d) must be reported to OIC as some health care benefit managers operate in states other than Washington and may perform services unrelated to health care benefit management.

We further request the OIC consider a reasonable period of look-back under section (1)(h) to be limited to the previous 5 years.

You may want to review the language in (4)(b) for potential typo. We believe the language is meant to be: "Any material change in the information provided to ~~the~~ obtain ~~n~~or review a registration…."

WAC 284-180-310
Health care benefit manager records
We would request additional clarity to the records maintained by benefit managers since there are myriad transactions that do not relate to the payment of a claim. We suggest the following change.
(1) (a) All records for each claim adjudication completed in the state of Washington.

WAC 284-180-320
Deadline to provide copies of records
We appreciate the OIC's recognition of adding "business" to the number of days allowed to make records available to the OIC to reflect current law.
(1) If the commissioner requests records for inspection for a purpose other than to resolve an appeal under RCW 48.200, a health care benefit manager must make the records available to the commissioner within fifteen business days from the date on the request.

While any health care benefit manager may respond, only the entity that is the subject of the complaint should be required to respond to the OIC. Consequently, we would request the following change.
(2) Upon receipt of any inquiry from the commissioner concerning a complaint, ~~every~~ the health care benefit manager that is the subject of the complaint must furnish the commissioner with an adequate response to the inquiry within fifteen business days after receipt of the commissioner's inquiry using the commissioner's electronic company complaint system. If the HCBM did not provide the services in question, the HCBM must inform OIC within 15 business days.

WAC 284-180-330
Required Notices.
We request OIC consider adding language in this section that it will concurrently inform the carrier and HCBM when OIC receives an inquiry or complaint.

WAC 284-180-455
Carrier filings related to health care benefit managers
We request compensation agreements be deleted as they are not required under the statute as benefit managers are required to submit contracts and contract amendments.
(1) A carrier must file all contracts and contract amendments with a health care benefit manager within thirty days following the effective date of the contract or contract amendment. If a carrier negotiates, amends, or a modifies a contract ~~or a compensation agreement~~ that deviates from a previously filed contract, then the carrier must file that negotiated, amended, or modified contract ~~or agreement~~ with the commissioner within thirty days following the

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effective date. The commissioner must receive the filings electronically in accordance with this subchapter.

We also request removing the requirement that reimbursement agreements be filed with the commissioner as it goes beyond the scope of the statute.

~~(4) If a carrier enters into a reimbursement agreement that is tied to health outcomes, utilization of specific services, patient volume within a specific period of time, or other performance standards, the carrier must file the reimbursement agreement with the commissioner within thirty days following the effective date of the reimbursement agreement, and identify the number of enrollees in the service area in which the reimbursement agreement applies. Such reimbursement agreements must not cause or be determined by the commissioner to result in discrimination against or rationing of medically necessary services for enrollees with a specific covered condition or disease. If the commissioner fails to notify the issuer that the agreement is disapproved within thirty days of receipt, the agreement is deemed approved. The commissioner may subsequently withdraw such approval for cause.~~

We understand that a health care benefit manager may not provide health care benefit services to a health carrier or employee benefits programs without a written agreement describing the rights and responsibilities of the parties conforming to the provisions of this chapter and any rules adopted by the commissioner to implement or enforce this chapter including rules governing contract content. However, we would request that whatever format the contract the parties agree to utilize be acceptable to the OIC. Reformatting could lead to contract inconsistencies and ambiguities and should be avoided. Consequently, we request that subsection (5) be amended to reflect the acceptance of the format agreed to by both parties in their contract.

WAC 284-180-460
Health care benefit manger filings
We request compensation agreements be deleted as they are not required under the statute as benefit managers are required.to submit contracts and contract amendments.

(1) A health care benefit manager must file all contracts and contract amendments between a provider, pharmacy, pharmacy services administration organization, or other healthcare benefit manager entered into directly ~~or indirectly~~ in support of a contracts with a carrier or employee benefits program within thirty business days following the effective date of the contract or contract amendment. If a health care benefit manager negotiates, amends, or a modifies a contract ~~or a compensation agreement~~ that deviates from a filed agreement, then the health care benefit manager must file that negotiated, amended, or modified contract or agreement with the commissioner within thirty business days following the effective date. The commissioner must receive the filings electronically in accordance with this chapter.

For subsection (2), we request the following clarifying amendments:
Health care benefit manager contracts must maintain health care benefit management contracts at its principal place of business in the state, or the health care benefit manager must have access to all contracts and provide copies to facilitate regulatory review within ~~upon~~ twenty business days after receiving ~~prior~~ a written request ~~notice~~ from the commissioner.

With regard to subsection (3), as we noted previously, we understand that a health care benefit manager may not provide health care benefit services to a health carrier or employee benefits

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programs without a written agreement describing the rights and responsibilities of the parties conforming to the provisions of this chapter and any rules adopted by the commissioner to implement or enforce this chapter including rules governing contract content. However, we are concerned the language in subsection 3: "...list or other format acceptable to the commissioner" could be incorrectly interpreted to mean the commissioner approves all contracts or agreements. Therefore, we request that subsection (3) be amended as follows:
The format of such contracts ~~and agreements~~ may include a list or other format capable of being electronically submitted ~~acceptable~~ to the commissioner so that a reasonable person will understand and be able to identify their participation and the reimbursement to be paid as a contracted provider in each provider network.

WAC 284-180-505
For purposes of consistency, we suggest the following change:

Appeals by network pharmacies to health care benefit managers who have identified that the health care benefit manager provides pharmacy benefit management services.
A network pharmacy may appeal a multisource generic drug reimbursement to a health care benefit manager providing pharmacy benefit management services..."

Thank you for the opportunity to provide comments on the proposed draft and appreciate your consideration of our requested changes. Please let me know if you have any questions regarding our suggested changes or need any clarification.

Sincerely,

Bill Head
Assistant Vice President
PCMA