Office of the Insurance Commissioner
Mandy Weeks-Green, Rules Coordinator
PO Box 40260
Olympia, WA 98504-2060

September 15, 2020

RE: Insurance Commissioner Matter R 2020-04

Dear Ms. Weeks-Green:

The Washington State Chiropractic Association (WSCA) appreciates the opportunity to make public comment regarding Insurance Commissioner Matter R 2020-04, health care benefit managers. The WSCA participated in your rule-making hearing on September 9, 2020 and provides the following comment in response to concerns raised at that meeting.

During the September 9, 2020 public hearing some carriers expressed confusion over the statutory definition of a health care benefit manager wondering where the "line would be drawn" regarding "directly or indirectly" impacting benefit determinations. As a primary proponent participating in the legislative stakeholder meetings on SB 5601, this definition was discussed repeatedly. The WSCA supports Senator Short's position that the definition is intended to be broad to capture companies who perform services on behalf of a regulated insurance carrier that affects patient care and access to health plan benefits.

In proposed WAC 284-180-240 there appear to be layout issues with the subsection numbering and lettering along with areas needing drafting attention. For example, in section 240 (4) (b), what is numbered as (4) (b) is quite confusing and probably includes unintended edits.

We support the OIC effort to capture information that reveals the names of benefit managers, who they work for and the services that are performed for each carrier with whom a benefit manager contracts; since some benefit managers work for more than one carrier in the same specialty, yet perform different services for each carrier.

The WSCA sees the potential for confusion over regulatory filing deadlines for provider contracts issued by carriers and benefit managers.

RCW 48.43.730 (2) states:

> *"A carrier must file all provider contracts and provider compensation agreements with the commissioner thirty calendar **days before use**. When a carrier and provider negotiate a provider contract or provider compensation agreement that deviates from a filed agreement, the carrier must also file that specific contract or agreement with the commissioner **thirty calendar days before use." (emphasis added)***

RCW 48.43.731 (1) states:

*"A carrier must file with the commissioner in the form and manner prescribed by the commissioner every contract and contract amendment between the carrier and any health care benefit manager registered under RCW 48.200.030, **within thirty days following the effective date of the contract or contract amendment." (emphasis added)***

Since carriers regularly use provider agreements that are written, distributed, and implemented by benefit managers (whether independently or on behalf of a carrier) how will the OIC apply these two statutes? How will providers know if the benefit management contract is in effect prior to the provider's receipt of a provider agreement, or within 30 days of the agreement? Carriers regularly amend provider agreements, including compensation provisions, with retroactive effect. dates occurring in the past. While this is not allowed for carriers currently, it will be allowed for benefit managers. Clarifying the relationship and effect of these statutes and their rules on provider agreements is important for providers.

With respect to the proposed language in WAC 284-180-455 (5), the WSCA would like to recommend the following language for consideration:

> "***Upon filing and approval, all changes to a contract must be incorporated into a newly revised contract capable of being read without reference to amendatory exhibits, attachments, and addenda and must be made available to providers in both a final form and a marked-up format with strikeouts and underlining that show additions and deletions from the prior contract. Provider contracts may not contain exhibits, attachments or other addenda that amend the body of the contract unless such exhibit, attachment, or addendum contains terms and conditions that supplement rather than change language in the main body of the contract such as a standalone compensation exhibit, list of plans subject to the agreement, or complete fully integrated terms and conditions for participation in a separate plan or program such as Medicare participation."***

Since provider agreement filing submissions to the OIC require these drafting formats to assist regulatory review and comparison to approved filings, it is appropriate for providers to receive these agreements in the same manner for the same reasons. Providers must be able to understand agreement changes that effect their practice, and their compensation for health care services, so providers can make an informed decision about to remain in the carrier's network, or not.

Finally, we find WAC 284-180-505 specific to pharmacy appeals and audits to be a solid appeal process that should apply to all health care benefit managers. We recognize the statutory limitations that apply to this rule but wanted to voice our support for future efforts to apply this process to all health care services.

If you have any questions about this public comment, please contact Lori Grassi, WSCA Legislative & External Affairs Director at 253-988-0500.

Sincerely,

Garry W. Baldwin, DC
WSCA President