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Jim Freeburg
Washington State Office of the Insurance Commissioner
PO Box 40255
Olympia, WA 98504-0255
Submitted by email to rulescoordinator@oic.wa.gov

June 17, 2016

RE: Prior Authorization pre-rulemaking stakeholder comments

Dear Mr. Freeburg,

The Arthritis Foundation, which serves 1.3 million adults and 6,100 children with arthritis here in Washington, appreciates the opportunity to provide comment on upcoming prior authorization rulemaking. For many of our constituents and their health care providers, prior authorization continues to pose a barrier to appropriate and timely care.

Because of physician workforce shortages and delays in referral, people with arthritis have often waited months for diagnosis by the time a rheumatologist prescribes treatment.[i] Unfortunately, appropriate therapy is often further delayed by utilization management techniques such as prior authorization. Data show that Exchange plans are more aggressive than employer plans in requiring utilization management tools for rheumatoid arthritis drugs. For example, 41% of drugs on Exchange plans compared to only 17% of drugs on employer plans require patients to go through at least one form of utilization management. [ii]

It is our hope that the rulemaking the OIC is undertaking will ensure that utilization management through prior authorization serves to facilitate more timely access for patients who would benefit from therapies to medically appropriate care. We ask that the Office of the Insurance Commissioner consider the following requests:

- **Ensure a timely turnaround for prior authorization.** While prior authorization timeframes have been previously addressed, we believe that it is important to continue to strive for consistently efficient turnarounds in approvals. The Arthritis Foundation recommends a maximum 48-hour turnaround for approvals.
    - In the event that a 48-hour turnaround is not met, the Foundation encourages consideration of an expedited process for patients who are continuing treatment on a previously approved drug for a chronic condition. For example, a patient who is approved in January for a biologic should not have to wait through a non-urgent process to renew an ongoing therapy for rheumatoid arthritis if the diagnosis has not changed.
    - Limit the frequency with which patients must have medications re-authorized so that patients do not spend multiple periods each year waiting for approval of a drug for which they have previously been approved.

- **Ensure greater transparency for providers** both prior to and during the approval application process and regarding the coverage outcome decision. Transparency is critical for consumers to know the reasoning behind an adverse coverage decision and how to appeal.

- Prior authorization systems should be in electronic format (at a minimum web-based) and should be a **single point of entry** for efficient, transparent access to information about coverage criteria for therapies that require prior authorization and other utilization management techniques, including, but not limited to step therapy.

- Criteria for approval of a particular treatment should be readily available prior to a provider seeking a coverage determination.

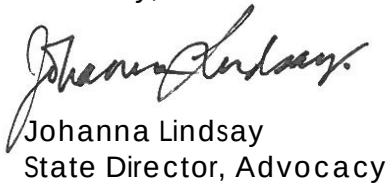
- Simplification of coverage determinations should also result in linking of prior carrier decisions specific to step therapy and other utilization management decisions.

- In the case of denial, written disclosures of an adverse coverage decision should be required, stating the specific reason for the adverse action, the period of time permitted to make an appeal, the form of the appeal, the location where the appeal must be submitted. We also ask that it be specified that an adverse benefit determination based on the insurer's internal standards or policies is insufficient information.

It is our hope that simplification of prior authorization requirements will reduce the administrative burden of delivering patient-centered healthcare, resulting in an increase in the availability of rheumatologists for patient care and the speed with which patients begin treatment for debilitating rheumatic conditions.

We appreciate the opportunity to comment and look forward to continuing conversation as rulemaking progresses.

Sincerely,



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[i] Diagnosis **of early rheumatoid arthritis: what the non-specialist needs to know;** E Suresh, MD MRCP; J R Soc Med. 2004 Sep; 97(9): 421–424.

[ii] Avalere Planscape ® (2015) Avalere analyzed formularies for silver plans participating in 8 states—6 relying on the federally-facilitated exchange (FL, IL, PA, TX, GA, NC), as well as CA and NY.