August 17, 2016

Mr. Jim Freeburg
Office of the Insurance Commissioner
State of Washington
P.O. Box 40258
Olympia, WA 98504-0258

RE: R 2016-19 (Prior authorization processes and transparency)

Dear Mr. Freeburg,

On behalf of Cambia Health Solutions family of health plan carriers, including Regence BlueShield, Asuris Health Northwest, BridgeSpan Health Company, we appreciate the opportunity to comment on R 2016-19, relating to prior authorization (PA) processes and transparency.

We fully support the OIC's stated goal of creating a rule that will streamline the PA process to benefit patients. The proposed rule does a relatively good job of achieving your goal. With that said, there are several areas that concern us from a health plan perspective. The following outlines our specific concerns section by section.

WAC 284-43-0160

We do not see a need for a definition of "emergency prior authorization request." In a true emergency situation, patients are held harmless. The scope of the rule before us is to deal with standard and expedited PA requests, not emergency medical situations.

WAC 284-43-2050

(1): Please remove the phrase "or as mutually agreed to by all parties" from the first sentence. The rule should state that carriers are to make sufficient information available to providers online so that providers are able to determine whether a service is subject to PA. Providers will be served well by a regulation that requires carriers to post what procedures are subject to PA online. Please note that licensing agreements we have with certain vendors bars us from posting proprietary information online, e.g., Milliman Care Guidelines.

(1)(a): Please remove the requirement that carriers include the name of the individual who denied a PA request from a provider. Providers should have access to contact information for the carrier who denied

the request. However, the name of the individual who issued the denial is not relevant and presents privacy and security concerns.

(1)(b): Please change the first sentence of this section to read: "If a provider requests prior authorization, the provider and enrollee must be notified if the authorized facility or provider is out of network, if known at the time of authorization." Often times, carriers do not know the actual facility or provider at the time of authorization. Therefore, the rule written as-is would be near impossible to implement.

(2): Please remove the language that requires carriers to "process" a PA request 24 hours a day. Carriers are able to accept PA requests 24 hours a day. However, it is reasonable to allow carriers to process the request during regular business hours. Patients experiencing a true emergency are protected by laws that hold the patient harmless.

(3): We appreciate that OIC is allowing carriers flexibility on creating an interactive website to facilitate PA requests. This flexibility will allow carriers to implement a cost efficient online portal that meets OIC's goal of PA streamlining.

(6)(a)(i): This section appears to be in conflict with WAC 284-43-2000, which allows carriers 5 days for non-urgent or standard requests. We suggest that OIC adopt the 5 day standard because it is closer to the industry standards put in place by entities such as Medicaid (HCA), Medicare, JACO, and URAC.

(8)(a): Please remove the language stating that carriers must "accept information from any reasonably reliable source that will assist in the authorization process." In your initial meeting you stated that you wanted to shift the burden of facilitating a PA request to the provider. In this section, you appear to be allowing for anybody to facilitate the PA request. It seems appropriate that any information relevant to the PA request should come through the requesting provider only, not outside sources. Outside sources are free to contact providers to help with a PA request.

(8)(d): Please reword overly broad language stating that carriers may not routinely request copies of medical records to render authorization. Carrier PA is based on the provider's medical records. Thus, routine requests for medical records is necessary to render an appropriate medical determination.

(8)(f): Please remove language stating that carriers must base review determinations solely on the medical information obtained by the carrier at the time of the review determination. Some PA cases involve services that are contract exclusions or hospital acquired conditions. Without reviewing previous claims information or old records, the information submitted at time of the request may not suffice and potential inappropriate authorizations will occur.

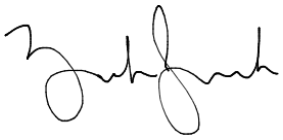
(11): Please remove or reword language stating that, in the case of a carrier withdraw from the market, a second carrier must "recognize the prior authorization of the previous issuer and ensure that the enrollee receives the services that were previously authorized as an in-network covered service." A carrier should not be bound to the PA approval of a previous carrier. Consider the following questions: What if the first

carrier's PA is for a service a second carrier does not cover, or does cover but the second carrier does not have a contract with the approved provider, or the second carrier does cover but the service is only covered with step therapy, or the second carrier does cover but the service is covered at much higher cost sharing, or etc? How would the second carrier know that the first carrier employed adequate requirements for approving a procedure? There are many more problematic scenarios.

In addition, this provision will act as a disincentive for a second carrier to take on the risk of individuals who are left without a carrier. The OIC should pursue regulations which incentivize carriers to cover individuals without a health plan. In addition, carriers should be able to apply its own processes when evaluating the need for PA.

I am happy to talk with your office about this rulemaking at any time. I can be reached at (206) 332-5060 or zach.snyder@cambiahealth.com.

Sincerely,



Zach Snyder
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