NoHLA
Northwest Health Law Advocates

Delivered via Email

August 17, 2016

OIC Rules Coordinator
Office of the Insurance Commissioner
Olympia, WA 98504

Re: Comments on proposed rule changes to regarding prior authorization – R2016-19

OIC Rules Coordinator:

Northwest Health Law Advocates (NoHLA) appreciates the opportunity to provide comments on Office of the Insurance Commissioner's (OIC's) draft changes to the rules regarding required disclosures about the coverage of pharmacy services. NoHLA is a Seattle-based non-profit organization that promotes increased access to quality health care and basic health care rights and protections for all individuals.

We wish to express our appreciation for the general thrust of the rules, which we think will provide greater certainty about the requirements for prior authorization governing health plans. We believe, however, that some elements of the proposed rules could be strengthened with the following changes or clarifications:

WAC 283-43-0160

"Prior authorization" – It would be helpful to state clearly in this definition if the term prior authorization applies to procedures used to address requests for authorization of services from out of network provider that would otherwise be covered from an in-network provider. The existing definition does not appear to include procedures to address such requests, as it focuses on whether a given health care services "is a covered benefit that meets the clinical requirements…in relation to the applicable health plan." This is arguably a separate issue from whether a covered service is reasonably available from an in-network provider, or whether an enrollee must be authorized to receive the covered service from an out-of-network provider. However, there may be some overlap between these two inquiries, such as when a health plan enrollee argues that it is part of the medical necessity of a procedure that it be delivered by a certain type of provider (e.g., a pediatric specialist), and no provider of this type is reasonably available in-network.

"Expedited prior authorization" – It would likely be helpful to define how the passage of time "could seriously jeopardize" the life, health or ability to regain maximum function of a covered individual, or include a citation to authority where these terms are defined or explained elsewhere.

WAC 284-43-2050

(1)(a) – We appreciate the proposed rule's requirement that a prior authorization decision must "be clear and explain…the justification for the decision, for example the prior authorization is denied because the service is a non-covered benefit." Sometimes the justification for a decision will be clear with little detail or supporting information. However, more often an enrollee (and her provider) will require more information to understand the justification for the decision and

4759 15th Ave NE, Suite 305
Seattle, WA 98105-4404
206-325-6464 ♦ nohla@nohla.org♦ www.nohla.org

determine whether and how to supplement a new request for the service or an appeal of the decision. The rule would thus benefit from clarification and be more useful to beneficiaries and health plans alike if it provided a clearer description of the types of information that must be provided as part of the "justification for decision." For example, we suggest that the rule provide that the decision/notice include: the specific facts relied upon in making the decision, any coverage criteria that were relied upon in making the decision, any provisions of the health plan that were relied upon in making the decision, and citations to any legal authority that was relied on in making the decision.

Also, it is unclear why a decision on prior authorization should include "the name and credential s of the **individuals who had the authorizing authority to approve or deny the request."** (emphasis added). It will certainly be useful to have a record of the identity and qualifications of the individual **who actually issued the prior authorization decision**. But, it's unclear why anyone else who might have had authority to issue the decision, but who did not actually issue the decision or participate in the decision-making process, should be mentioned. We suggest that the language be changed accordingly to "…the individual(s) who made the decision or participated in the decision-making process."

(5)(b) - We appreciate that issuers are required to notify providers of deficits in the information the providers submitted in support of a prior authorization request, as well as the deadline for supplementing that information. However, the proposed rule seems to require such notice only when the prior authorization request was submitted by a provider, and that the notice be delivered only to the provider who submitted the request. An enrollee who submits a request without enough evidentiary support for the issuer to make a decision about whether to grant the request deserves notice of this just as much as a provider who submits the request. Also, even when the provider submits the request, it will be helpful for the plan to send notice of the request's informational deficit and the deadline for supplementing that information to ***both*** the provider and enrollee. This automated issuance of such an additional notice would cause at most a minor inconvenience to health plans, but would help enrollees become promptly informed when additional information is needed (which they may need to locate and give to their providers) to approve requests for medical services they require. This will also help patients hold their providers accountable for following up on such notices and supplementing the prior authorization requests in a prompt and timely manner.

(5), (6) The term "review" seems to be unnecessary in these sections. For clarity, it should be deleted or replaced with "authorization," "decision," or "determination." If something significantly different is intended to be meant by the term "review" in these sections, it should be stated more clearly.

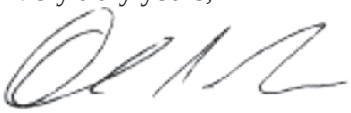
(8)(c), (d) – The proposed rule indicates that issuers may "**[n]ot routinely"** either require numerically coded diagnoses/procedures or request copies of the medical records of enrollees for whom services are being requested. These sections would benefit from clarification. We agree that neither numeric coding of diagnoses/procedures or the requisitioning of an enrollee's medical records should generally be required for an issuer to make and issue a prior authorization decision. As written, however, the proposed rule appears only to preclude health plans from establishing a blanket requirement that would "routinely" (i.e., always) require such actions. Plans could easily establish procedures that allow them to require these coding practices and record requests at their discretion. This discretion could then be exercised to require such

practices and requests in all or nearly all cases without arguably violating the rule. This can't be what was intended in creating such a rule in the first place. We urge that the rule make clear that neither coding nor record requests of the type described by the rule may be required by issuers to grant a prior authorization request. If your office believes that there are narrowly circumscribed conditions under which coding or broad record requests should be required, the rule should state with greater specificity the circumstances when an exemption from the general presumption against such practices is allowed.

(13) – We appreciate the proposed requirement that issuers' prior authorization programs comply not only with the minimum requirements laid out in the rules, but that they also meet "accepted national certification standards such as those used by the National Committee for Quality Assurance." It would be helpful, however, to state more clearly what sort of criteria for assessing an issuer's prior authorization procedures will be considered "accepted national certification standards," besides the NCQA guidelines.

Thank you for giving us this opportunity to comment on the proposed rule governing prior authorization of medications. We look forward to continuing to work with your office to develop rules governing this important process. If you have any questions about this, please contact Daniel Gross at 206-325-6464 or at Daniel@nohla.org.

Very truly yours,



Daniel Gross
Senior Staff Attorney