PREMERA | BLUE CROSS

via e-mail to: rulescoordinator@oic.wa.gov

August 3, 2016

Mr. Jim Freeburg
Special Assistant to the Commissioner
Policy & Legislative Affairs
Office of Insurance Commissioner
P. O. Box 40258
Olympia, Washington 98504-0258

Subject: R 2016-19 Prior Authorization Process and Transparency

Dear Jim:

Thank you for the opportunity to comment on the OIC's rulemaking considerations in the context of prior authorization processes. We appreciate being a participant in the recent stakeholder meeting on this subject, and the information and positions presented at that meeting. And we have reviewed your stakeholder draft released on July 15, 2016.

The purpose of this letter is two-fold: to restate what we believe are significant elements that must be kept in mind during any rulemaking on this subject, and to offer specific feedback on the draft. This letter is being submitted on behalf of Premera Blue Cross, LifeWise Health Plan of Washington, and LifeWise Assurance Company ("Premera" or "the Companies").

Key Points for Rulemaking

We urge your office to take into account the following key points as work on the rulemaking progresses:

- As stated in the meeting, prior authorization is a necessary element of utilization management, because approaches to medical care vary widely. It behooves issuers to do their best to ensure, and therefore to provide coverage for, the most effective and safest care for their enrollees. The process for prior authorization must be viewed in this light.

- We respectfully suggest that the burdens for ensuring a streamlined and efficient process cannot be unilaterally imposed on just the issuers. A set of rules that requires issuers to conduct the intake review for all requests, and notifications about deficiencies, in a very short time accomplishes nothing in terms of encouraging complete, high-quality, and well-documented review requests submitted by providers. Instead, such a one-sided burden ultimately rewards poorly supported requests, and penalizes the enrollee by increasing issuers' administrative costs.

- Please keep in mind that emergency care does not require prior authorization. Unlike pharmacy prior authorizations, where the need for medication fills, and availability of pharmacies, in fact do exist even on weekends. A preplanned medical service does not present the same level of urgency, and we strenuously object to a requirement for 24/7 reviewer availability. The potential administrative expense is not justifiable.

Stakeholder Draft

Having reviewed the draft, we have the following initial comments and concerns, and respectfully ask that further discussion and draft review be undertaken to ensure the rule focuses on those elements where further clarity is called for, without causing the kinds of issues already raised in our comments above.

- Definitions in WAC 284-43-0160: the terminology in the draft definitions describing prior authorization, and request therefor, draws no distinction between requests that are required in order for contract benefits to be provided, and requests done at the option of the provider. Contractually required prior authorizations are already subject to a number of stringent federal and state rules, in particular those for "pre-service claims." Sweeping voluntary prior authorization requests into the same category for turnaround times and other requirements causes confusion about the rules that in fact should apply. It also increases administrative burdens and costs.

  We are also concerned about the conflict and confusion created when the draft definitions are compared against the current review definitions in WAC 284-43-2000. They do not match and create confusing consequences, see below.

- New section -2050: Draft subsection (1)(b) does not appear to take into account the possibility that a facility for a proposed service or procedure may not yet be known. This is even more significant in the context of draft subsection (4) where the enrollee may not yet have been seen by the specialist

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  For our concerns regarding draft subsection (2), please see comments above; we object to a 24/7 requirement as being excessively costly and burdensome, as well as unnecessary.

Draft subsection (4) would seem to raise the possibility of needlessly redundant reviews when, upon seeing the enrollee, the specialist determines that a different course of treatment is advisable.

- Turnaround times in -2050: In addition to the comments above under the Definitions items, we are concerned, given the broad and somewhat vague nature of the draft definition, about the inconsistent turnaround times between the draft and existing rules. To mention but one, quite significant, example: subsection (6)(b)(iv) of the existing rule in WAC 284-43-2000 provides five days for a non-urgent preservice request. Your draft refers to standard prior authorization requests and provides 72 hours.

  We respectfully object to these major changes in applicable requirements in a rule whose stated goal is to streamline processes and make them more transparent. The above changes go well beyond that.

  An additional issue regarding turnaround times that we wish to call to your attention relates to the comments made above regarding one-sided burdens. First of all, in effect, the requirements for notification to the provider of insufficient supporting documentation mean, in practice, that all prior authorization requests must have an initial review within the shortest of all listed timeframes, namely 24 hours, in order to ensure that the level of urgency is identified along with the need for additional documentation. This, along with the requirement in subsection (2) for 24/7 availability, strikes us as entirely unreasonable.

  We believe that it is appropriate for issuers to deny insufficiently documented requests based on the initial submission only, within the decision timeframe specified in the rule draft, on the basis that the request has not been adequately supported. (The exception would be minor, *de minimis* deficiencies, which can readily be cured.) The provider has the option to resubmit the denied request with full documentation. Keep in mind that adequacy of documentation should be a provider responsibility, and that prior authorization does not apply to emergencies.

  Subsection (7) of the draft provides for 45 days' validity for prior authorizations. Such a lengthy time period is, in our view, acceptable only if it is modified by a provision that addresses loss of eligibility under the plan (including moving to another issuer). A period of 45 days means that an individual could be without coverage, not paying premiums, for two months and still receive benefits for pre-authorized services (including voluntary benefit determinations under your new definitions). We question that this is what OIC would intend.

- Market withdrawal: Subsection (11) of the draft raises two concerns that need to be addressed. One is to clarify that the enrollee or the provider must furnish the details of the prior authorization obtained from the prior issuer to the issuer of the new plan, in order for this provision to apply. The second, and far more significant, is the requirement to provide such pre-authorized services

as in-network. The network of the new issuer may not include all of the same providers as the previous network, thus necessitating a change in providers; if the enrollee chooses not to make such a change, the issuer cannot ensure in-network coverage.

- Provider contracts: Subsection (14) defines all changes to prior authorization procedures as constituting provider agreement changes. We believe this is unreasonably broad and burdensome. Details of prior authorization procedures are not currently included in the Companies' provider agreements, nor would it be practical to include them all. One consequence, in light of the frequent and rapid changes within medical care, could be a flood of provider agreement amendments to be prepared by issuers, filed for review by your office, and sent to many thousands of providers. A possible other consequence might be that benefit coverage for a newly available medical treatment that warrants prior authorization will be delayed until it is practical to amend the provider agreements at a later date. We respectfully request that you delete this provision, or modify it following further discussion, in a manner that addresses the concerns that the rule is intended to resolve.

The above points are the key concerns we have identified, at this stage, with the rule draft. We appreciate your office's scheduling of a stakeholder discussion to go over this draft, and look forward to participating. Overall, the Companies continue to believe that the objective of the rulemaking remains somewhat unclear. As stated above, we believe many of the changes to existing rules go well beyond a mere streamlined and transparent process, but instead impose additional, costly burdens on issuers without establishing clarity regarding the problems that this rulemaking is attempting to address. We believe that further discussion is imperative, and we look forward to working with you on this topic.

Sincerely,

Waltraut B. Lehmann

Waltraut B. Lehmann
Manager, Regulatory Affairs