PREMERA | BLUE CROSS

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October 12, 2016

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

Subject: OIC Rule Draft R 2016-19 – Prior authorization process

Dear Jim:

Thank you for the opportunities to discuss, and comment on, the OIC's drafts for rule language addressing the prior authorization process. We have given in-depth consideration to the latest draft in light of the concerns that it is intended to address, and we offer the comments and suggestions in this letter in the spirit of ensuring that a necessary process does not become even more burdensome, more costly, and more frustrating for everyone involved – not just issuers, but also providers and ultimately members. This letter is being submitted on behalf of Premera Blue Cross, LifeWise Health Plan of Washington, and LifeWise Assurance Company (collectively "Premera" or "the Companies").

A key element of our suggestions in this letter is our conclusion that the rule language as currently drafted would result in unintended consequences. We also believe, based on the Companies' participation in the administrative simplification workgroup through OneHealthPort (OHP), that some of the draft provisions that have been pulled from OHP's best practices recommendations have been altered in such a way that they no longer match the recommendations.

To begin with, we would like to offer some general suggestions, intended to address a set of overarching concerns we have identified in the rule draft. We understand that there are provider situations that are unique, limited to certain types of situations, and not neatly categorized in existing approaches to prior authorizations. We agree that such situations should be addressed, but the rule must do so in a workable manner. We suggest alternatives aimed at avoiding an excess of confusing and impractical definitions and requirements that bring with them costly new processes.

Prior authorizations and post-service reviews

Specifically, there is no need to impose a medical prior authorization process requiring handling outside of business hours. Such a process would necessitate staffing at the appropriate levels not only at the issuer's end, but also for the providers. Example: provider submits an urgent or expedited request on a Friday morning; by Friday evening or Saturday morning, the issuer identifies lack of certain documentation and notifies the provider, who has 48 hours – i.e., until Sunday evening or Monday morning – to supplement the request. Imagine holidays added into the mix, and the impracticality of having to have staff on hand, just in case, becomes even more evident. Here are our more detailed comments and suggestions in this context:

- Emergencies cannot be subject to prior authorization requirements; therefore they do not present an issue.

- Non-emergent situations that require fast actions by the provider can be handled via alternatives. Specifically, we believe that when the situation calls for such fast actions and business hours would present a potential barrier, the rule should provide for handling by way of post-service review.

  We recommend a rule provision that addresses handling of situations where a prior authorization would normally be required, but where the timing factors do not allow the request to be processed as needed. As a result, the alternative process of post-service review would apply. Services that qualify under the parameters (to be defined) for these instances would not be denied for lack of a prior authorization. If the enrollee's contract covers the service, and if the service is determined to be medically necessary, regular contract benefits would be provided. It is true that this would result in the denial of a claim if the service is not medically necessary or appropriate.

  Criteria for handling such post-service reviews in lieu of otherwise required prior authorization would establish uniformity and transparency for the process for all issuers and for providers as well as their patients, and would ensure that medical care and service that must be handled on a short timeframe can go forward as needed.

- Establishing a post-service process will eliminate the need for a number of rule provisions in the current draft that are particularly confusing, burdensome, and costly. These provisions, in Premera's view, include but are not necessarily limited to: immediate request and the exceptions thereto; 60-minutes' turnaround; special requirements for ambulance transfers; and acceptance and handling of prior authorization requests outside of normal business hours.

  We also believe that some of the issues raised by providers fall within the parameters for concurrent review, not prior authorization, and they can and should be addressed as such.

Other comments

In addition to the above, we also note the need to revise the following rule sections:

- WAC 284-43-2050(13): we appreciate the attempt to restrict the validity of a prior authorization in a manner that serves the needs of all involved, including especially the patient. But we are concerned that 45 days is too long a time period, given that even a loss of eligibility or coverage under a plan does not permit the issuer to deny, retrospectively, a pre-authorized service. A prior authorization issued near the end of a month would be valid into the second month following. As a result, an enrollee who ceases to pay premiums at the end of the month in which the authorization was issued would be within the second month of non-payment for coverage and would still be entitled to have potentially high-cost services covered. This is not an acceptable outcome in our view, and penalizes those enrollees who do maintain their continuous coverage, by the increased premium rates they would face. We urge you to shorten this time period.

- WAC 284-43-2050(16): while we recognize the very limited applicability of this provision, recent history has shown that an issuer's market exit is not out of the question. We believe that the requirement for a new issuer to honor an exiting issuer's prior authorization raises several significant concerns. The coverage available, and/or the criteria for authorizing benefits could vary widely between issuers and benefit plans. Furthermore, we continue to object to the in-network benefit provision. The new issuer would not be able to force a provider who is not contracted in its network to accept network payments or conform to other network requirements.

- WAC 284-43-2050(18): we urge you to clarify this subsection to state that only those provisions already set forth in the provider agreement would require a contract amendment. As an example, if every instance where a new medical service is added to, or an existing service is eliminated from, the list of what does and does not require prior authorization requires amending the provider agreements of the issuer, the effect could be a large increase in filings prepared by issuers on a regular basis, resulting in more submissions for review by OIC, and more contract amendments sent to providers. The same would be true for procedural details that would normally be communicated in the context of instructions for submitting a prior authorization request, such as on the issuer's website. Incorporating all such details into the provider agreements is neither reasonable nor necessary, and we ask that you clarify the provision accordingly.

In addition to the specific comments above, we also wish to respond to your question at the meeting regarding a practical effective date, which the current draft specifies as January 1, 2018. Given the potentially wide variation in the amount of work issuers will need to accomplish in order to implement some features of the contemplated regulation, at this time Premera believes that January 2018 would be the very earliest date that might be reasonable. However, in light of the additional work that is needed on the rule draft before proceeding to the formal proposal stage, and our expectation that your rule team will include a number of substantive changes, a date is difficult to comment on; we will be able to do a better assessment of time needed once revised rule language is available.

In this context, we also offer comment on the proposed next steps you communicated at the meeting. It is unclear to the Companies why the OIC would rush to a CR-102 now, instead of developing an additional draft. You have received significant comments and have indicated you are open to reconsidering a number of rule provisions. This may well entail elimination of some rule sections, and rewriting of others. That is, in fact, what we respectfully ask you to do, based on the suggestions above in this letter. We believe it will be more efficient and useful to allow the extra time prior to the formal rule proposal to ensure all concerns are addressed, rather than find substantive changes necessary after the CR-102 is published, which would cost more time. Therefore we ask that you re-evaluate your plan for next steps.

We look forward to continuing our engagement with your office on this rulemaking and respectfully urge you to accept and apply these comments. We also understand that the Association of Washington Healthcare Plans is offering detailed comments; we support the Association's position, even where we do not repeat the same points in this letter. Please contact me if you have questions.

Sincerely,

Waltraut Lehmann

Waltraut B. Lehmann
Senior Manager, Regulatory Affairs