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January 27, 2023

VIA ELECTRONIC MAIL

Honorable Andrew Stolfi
Director, Insurance Commissioner
Department of Consumer and Business Services
350 Winter Street NE
Salem, OR 97301-3883

Subject: Regence BlueCross BlueShield of Oregon – Reproductive Health Equity Act Market Conduct Examination Final Report

Dear Director Stolfi,

Regence supports access to reproductive health services for all Oregonians and was also supportive of legislation that became the basis for the Reproductive Health Equity Act (RHEA). We remain committed to working with the Division of Financial Regulation (DFR) to ensure consistent implementation of the law going forward. Throughout the examination process, we have been forthcoming, honest, and responsive to the examiner and the DFR in addressing the underlying concerns that precipitated this examination.

We have implemented the RHEA statute in good faith and with best intentions to comply with the statutory requirements as we read them. When the statute was silent or ambiguous, in the absence of additional state regulations and guidance, we relied upon federal regulations and guidance pursuant to the Affordable Care Act (ACA) women's preventive care requirements to fully implement the RHEA statute. Additionally, we undertook a robust implementation process with participation of many areas of our organization. This process included medical policy development, systems configuration, and the education of member-facing and claims processing teams.

Regence used the limited information that was available at the time of implementation and acted in good faith to operationalize the RHEA statute's requirements. The results of the market-wide examination demonstrate inconsistency with how the RHEA statute has been interpreted and underscores the need for a formal rulemaking process to implement this important and technical Act. We are pleased to hear that your office plans to undertake a formal rulemaking to collectively and collaboratively work with carriers and providers to ensure that the RHEA statute is implemented in a sustainable and consistent manner across the market, taking into consideration well-established industry standards for carriers and providers.

We remain concerned about certain findings identified in the state's final report as outlined here, as the report's language does not reflect our reasonable approach to implementing the RHEA statute based on information that was made known to carriers at the time it took effect.

FINDING 1: Noncompliance with ORS 743A.067 relating to the processing of claims

As we have stated, we look forward to engaging in the formal rulemaking process to ensure the RHEA statute is implemented in a sustainable and consistent manner across the market, taking into consideration well-established industry standards for carriers and providers. We believe that rulemaking should include three issues identified in our report and enumerated here: provider billing using generic current procedural terminology (CPT) and diagnosis codes, what Well Woman and preventive visits include, and how facility-based claims are processed.

Issue 1: Provider Billing using Generic Current Procedural Terminology (CPT) and Diagnosis Codes

It is industry standard practice to adjudicate claims based upon the specific codes a provider supplies within the claim. Carriers and providers together use industry standard coding practices and procedures to ensure that claims accurately reflect services rendered and include sufficient detail to ensure accurate payment. When providers bill using generic CPT codes or diagnosis codes for an office visit or service, the associated claims cannot process as RHEA-specific covered services without additional specific CPT codes or diagnosis codes billed on the claim to ensure the office visit or service is covered under the RHEA statute. Such additional information is standard industry practice and consistent with standard coding procedures. It would be inappropriate to cover general office visits and services at 100% if it is not clear that such services are listed within the statute.

Issue 2: Well Woman / Preventive Visits

The final report concluded that in instances where "a woman went in for a preventive visit and tests are conducted which would not normally be considered RHEA screenings, i.e., blood panels, labs, etc., such services would still need to be covered under the RHEA law if listed as a covered screening." This statement suggests that the application of the RHEA statute is much broader than is stated in the statutory text. Such increase in scope of application of the RHEA statute would lead to a significant increase in health plan costs, as additional general non-RHEA related medical services and tests would then be required to be paid at 100%. Such an approach is also inconsistent with the intent of the RHEA statute, federal requirements, and industry standards. For example, ORS 743A.067(2)(a) requires coverage of "well-woman care prescribed by the Department of Consumer and Business Services by rule consistent with guidelines published by the United States Health Resources and Services Administration (HRSA)." The HRSA guidelines to which the statutory text refers define a discreet list of services

that are to be included in well-woman care. HRSA and other federal government agencies have not taken the position that extraneous services provided at the same time but not integral to furnishing the recommended well-woman care are to be also covered without cost-sharing. This position is further supported in federal guidance, FAQs About the Affordable Care Act Implementation Part 54 (July 28, 2022) Q/A #1, which requires issuers to only cover items and services that are integral to the furnishing of a recommended preventive service without cost-sharing. In the absence of state rulemaking and/or formal guidance, applying cost share to non-RHEA services should not be considered non-compliant based upon the RHEA statutory text in conjunction with cited HRSA guidelines.

This issue is illustrated within our claims sample. There were instances where claims for preventive visits processed at 100% coverage, but other non-RHEA/non-preventive testing services rendered at the same time and billed as a separate line-item by the provider were appropriately processed to the deductible. The adjudication of this claim was consistent with a reasonable interpretation of the statutory language of the RHEA requirements and information carriers had at the time of implementation. There was no reason for carriers to believe that *all* treatments, labs, or services provided during the same visit as a preventive exam, regardless of their diagnostic nature, should have been covered at 100%.

Issue 3: Facility-Based Claims

For certain facility-based claims (e.g., hospital stays, maternity, etc.), common industry billing practice is to pay the claim at the claim level (all services bundled) and not the line level, as the services are not submitted by the provider facility to the carriers as separate claims. This industry standard is reflected and accounted for within Federal regulations implementing the ACA Preventive Services requirements based upon extensive feedback from carriers and providers during the rulemaking process. The regulations provide for a “primary purpose test” for health plans to use in determining whether a claim that is submitted with a mix of services included, but not billed separately, is considered “preventive services” under the ACA Preventive Services requirements. 45 CFR 147.130(A)(2)(iii) states, “If an item or service described in paragraph (a)(1) of this section is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is not the delivery of such an item or service, then a plan or issuer may impose cost-sharing requirements with respect to the office visit.” The regulation also includes four separate examples to illustrate how the “primary test” requirements are applied in certain circumstances.

In the absence of state regulations or guidance pertinent to the technical implementation of the RHEA statute, we reasonably utilized the applicable federal regulations regarding the “primary purpose test,” as stated above, to determine whether cost-sharing applies for combined facility-based claims.

FINDING 2: Noncompliance with the requirement to reimburse 12-month contraceptive prescription refills as required by ORS 743A.066 and noncompliance with contraception coverage requirements under ORS 743A.067

In the examination report, the examiner asserts that Regence violated the RHEA statute by covering contraceptive prescriptions for a three-month period, rather than a one-year period.

Pharmacists are required to process prescriptions as they are written by the provider. This means that if a provider writes a contraceptive prescription for a three-month supply with four available refills, the member will only be able to fill that prescription in three-month segments. Additionally, a provider may choose to prescribe contraceptives for less than a 12-month supply for a number of reasons. Some of the most important reasons can include better oversight of potential safety, effectiveness, or tolerability issues unique to the member's health situation. The decision about length of prescription supply rests solely with the prescribing provider and should not be overridden by the pharmacist or covered by the carrier in a manner inconsistent with the prescription.

Refill-too-soon edits play an important role in ensuring pharmaceutical safety along with preventing fraud, waste, and abuse. However, it is important to note that such edits do not limit in any way the member's ability to receive the full quantity as prescribed. To illustrate, if the member fills a contraceptive prescription for three months and then goes to the pharmacy for a refill, the member would be eligible to receive the refill as long as the required percentage of time had elapsed since the last fill (example: If a member fills a three-month contraceptive prescription January 1, the member would be eligible to refill the prescription on March 8, or once 75% elapsed time passed). The member would still be eligible for the refill whether the provider wrote the prescription for a three-month fill or updated the prescription to allow for a 12-month fill. If the member received a full fill of a specific contraceptive drug – even up to 12 months – and then determined that the drug was not well tolerated, they would not be limited from immediately filling a prescription for a different contraceptive. Refill-too-soon edits apply only when a member has already received a fill of a specific drug at a specific day supply as written by the provider and then is requesting a refill of that exact same drug.

To ensure that access to important prescription drugs such as contraceptives is not hampered, there are many exceptions to this policy (e.g., state of emergency, wildfire, medication damaged/lost). Furthermore, we believe that ORS 743A.066(2)(a) permits carriers to impose refill-too-soon edits on contraceptives because such edits apply equally to other prescription drugs covered under the health plan.

The examiner makes the case (page 11) that some individuals choose to or are counseled by their provider to skip the placebo week. If that is the case, the standard practice is that the provider adjusts the prescription to a 21-day supply commonly known as a “continuous fill” to

ensure the patient receives the necessary amount of contraceptives to account for the placebos. We have no objections to reimbursing for continuous fill contraceptive prescriptions and currently do so when they are written as such by a provider. Regence is covering prescriptions as written by providers and filled by pharmacies in a manner consistent with laws and cannot disregard the duration and frequency of a prescription as determined by that provider. While we cannot be responsible for the actions of a prescribing provider, we look forward to working with your office as you determine how the DFR can help educate providers on their options for writing contraceptive prescriptions as allowed by Oregon's laws.

Conclusion

As we have detailed above, Regence used all information that was available to carriers at the time of implementation and acted in good faith to operationalize the RHEA requirements. We support the intent and spirit of this important law to provide access to reproductive health services and contraceptives for Oregonians. The results of the market-wide examination indicate inconsistency with how the RHEA statute has been interpreted and implemented. Therefore, we ask your office to use this exam to help identify how we can collectively and collaboratively work together to ensure that the RHEA statute is implemented in a sustainable and effective way. We look forward to the formal rulemaking process your office has stated it will undertake, which would ensure market-wide consistent implementation of the RHEA statute and give all stakeholders, including providers, an opportunity to provide input on the implementation of specific requirements under the RHEA statute. This approach is particularly important to ensure that expectations for the implementation of the RHEA statute are consistent with long-standing industry standards upon which provider and carrier systems have been built.

Sincerely,

Christopher G. Blanton
Senior Vice President of Health Plan Operations, Commercial and Ancillary Markets
Regence BlueCross BlueShield of Oregon