American Hospital Association™
Advancing Health in America

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Gail K. Boudreaux
President and Chief Executive Officer
Anthem Blue Cross and Blue Shield
220 Virginia Avenue
Indianapolis, IN 46204

Dear Ms. Boudreaux:

America's hospitals and health systems have deep concerns about several Anthem policies that challenge their ability to care for patients during the COVID-19 global pandemic. We call on Anthem to reverse course immediately.

Specifically, our concerns include Anthem's frequent changes to enrollees' coverage, delays in patient care resulting from excessive prior authorization requirements and growing failure to pay claims in a timely manner. Taken together, these issues are creating an untenable situation. Patients are facing greater hurdles to accessing care; clinicians are burning out on unnecessary administrative tasks; and the system is straining to finance the personnel and supplies needed to meet the demands of a surging fourth COVID-19 wave.

Additional details on these issues follow.

UNILATERAL, MID-YEAR CHANGES TO PATIENTS' COVERAGE

Anthem has implemented a number of coverage policy changes during the past 12-18 months that restrict where enrollees can access covered services. Specifically, Anthem, in the middle of an enrollee's plan year, changes where the enrollee may receive a covered service. For example, Anthem may newly require the enrollee to go to an ambulatory surgical center instead of a hospital outpatient department for a certain surgery or require that the enrollee receive a specialty drug furnished by its vendor and not by the treating provider's own pharmacy. These restrictions apply to services provided at *in-network* facilities and, therefore, are confusing for both patients and their providers. In other words, the provider is represented as in-network to the enrollee (for example, the hospital outpatient department); however, Anthem no longer will cover certain services delivered by that provider. Anthem has applied such coverage policy changes to a number of outpatient services, including certain surgeries, imagining and radiology, and specialty pharmacy, among others.

These policy changes raise substantial concerns regarding access, quality and timeliness of care delivery. They also add more complexity to the system for patients. Some of the most concerning examples relate to Anthem's specialty pharmacy policies that require providers to administer drugs to patients provided by an Anthem vendor and not drugs that the providers themselves have acquired and properly stored and handled. Under these policies, cancer patients and others requiring complex, physician-administered drugs like chemotherapy are reliant on an outside vendor to send the necessary drug. If the drug does not arrive on time, or the wrong dose is sent, or the drug was mishandled in route, the provider often cannot proceed with care and must reschedule the patient.

Changes in coverage policies for outpatient surgeries and diagnostic services can have similar effects: Patients are separated from their longstanding providers and delays occur as alternative providers are located. In some cases, Anthem steers the patient toward providers that are unaffiliated with their primary care team, which adds to the complexity of coordinating care for the patient. These delays and the disaggregation of care can have a direct effect on health outcomes.

Anthem introduces these changes in coverage policies throughout the year, and as a result, they amount to a "bait and switch" on consumers. In many cases, an individual or family (or their employer) selected an Anthem plan specifically because of its provider network. However, once they have purchased the coverage, many of those providers are no longer available for certain services.

This convoluted approach to "in-network" care confuses patients and will inevitably increase their out-of-pocket costs. This will occur if the patient either chooses to continue seeing their trusted providers at their own expense or unknowingly accesses a service that is later denied by the plan. We expect many of these patients will receive a surprise bill that is not subject to the patient protections included in the No Surprises Act.

Enrollees should be assured that the policy they bought provides the services and network it promised. We ask that these unilateral, mid-year coverage restrictions stop altogether.

PRIOR AUTHORIZATION COMPLEXITY AND DELAYS

Anthem's application of prior authorization processes has contributed to delays in patient care, excessive burdens on clinicians, and inappropriate denials of medically necessary care. Such processes are now applied to a wide range of services, including those for which there is no evidence of lack of compliance with clinical guidelines, such as post-surgery rehabilitation and cardiac diagnostic services. Adding further complication, authorization requirements vary by line of business. In other words, Anthem often applies different rules depending on whether the patient is in, for example, an individual market plan or a Medicaid managed care plan. Finally, Anthem relies on subcontractors, such as AIM Specialty Health, to manage these processes, and clinicians often report that they receive different guidance from Anthem and AIM about whether prior authorization applies and the requirements for

making requests. When AIM denies a prior authorization request, the subcontractor directs the provider to Anthem for appeals. At this point, Anthem often requests providers send the exact same documentation already provided to their subcontractor, duplicating an already burdensome process.

We also have significant concerns about emerging reports that Anthem now requires the treating provider to speak with Anthem as part of certain prior authorization requests. While peer-to-peer discussions are not abnormal, requiring that these discussions include the treating physician is not normal. This requires providers to literally leave the patient bedside to get on the phone with Anthem. The call must be made within a narrowly prescribed timeline without regard for whether the treating provider is with patients at that time. As a result, providers often cannot make these calls and authorizations are delayed.

Despite these ongoing problems, Anthem recently expanded its contract with AIM to conduct prior authorization medical necessity and other utilization management reviews for outpatient rehabilitation services. This rollout was done without sufficient warning to clinicians and with inadequate education about the new rules and operational processes. In fact, the web portal did not appear to be fully functional at the time of launch – a number of clinicians reported that the rehabilitation tab either was removed completely or was disabled.

While pre-authorization has its place in the role of a managed care organization, the expansiveness and ever-increasing hurdles in Anthem's processes far surpass what is reasonable. **We call on Anthem to take steps to reduce the burden and complexity leading to patient care delays and clinician burnout.** These include: relaxing prior authorization requirements for services that historically have high rates of approval, e.g., more than 95% of the time; ensuring alignment with subcontractors on prior authorization rules and processes; conducting sufficient provider education in advance of policy changes; eliminating instances of multiple record requests; and eliminating the requirement that the treating provider speak with an Anthem representative.

SUBSTANTIAL CLAIMS ADJUDICATION DELAYS

Hospitals and health systems across the country are reporting substantial delays in Anthem's adjudication of claims. One health system reports more than $102 million in Anthem claims have exceeded the prompt payment timeframe allowed in state law. For another health system, delayed payments have reached $148 million. The claims processing delays create financial burdens for patients by forcing them to wait months to receive an explanation of benefits and understand their final out-of-pocket costs. When the patient ultimately does receive their bill it can come as a surprise as so much time has passed. It also creates burden on employers who are not receiving timely notices to fund premiums – leading them to not know their true cost of employee benefits.

We understand these delays are the result of a new claims management system deployed by Anthem earlier this year. The problems appear to include both technical systems issues and errors, such as the incorrect loading of fee schedules. While new systems can have glitches,

the delays in payment have gone on for many months, and despite Anthem's deployment of its "High Abrasion Resolution Team," the delays persist without meaningful improvement. **The financial stress this places on providers could not come at a worse time in light of surging COVID-19 cases and increased costs associated with staffing and supplies to meet the demands of the public health emergency.** Meanwhile, Anthem reported $1.8 billion in income for the second quarter of this year.

All of these policies take us further away from the coordinated, accessible, affordable health care system we envision for our communities. We urge you to take immediate steps to remediate these issues.

Sincerely,

/s/

Richard J. Pollack
President and Chief Executive Officer

Cc:

Xavier Becerra, U.S. Department of Health and Human Services
Chiquita Brooks-LaSure, Centers for Medicare & Medicaid Services
Ali Khawar, Employee Benefits Security Administration
Lina Khan, Federal Trade Commission
Richard Powers, U.S. Department of Justice
Tim Wu, National Economic Council