Chair Houghton and Committee Members:

In follow up to the 1/17 Committee discussion of H.766, provided below is a written copy of my comments on the bill's prior authorization components.

General Comments – MVP Perspective on Prior Authorization

- We acknowledge your concerns regarding the unnecessary complexity and administrative burden in healthcare. The system is overly complex and costly.
- Our goal is for our members to receive the necessary care that improves their health and quality of life. Unnecessary administrative burdens or obstacles leading to care denials and delays are detrimental to everyone.
- Negative customer experiences can prompt our members to switch health insurers, resulting in the loss of their business. Similarly, when our provider partners have a bad experience, it can harm our reputation locally and strain the essential partnerships needed to serve our members effectively.
- Prior authorization policies are also costly for MVP. They necessitate staff time to review requests and maintain policies, additional resources to handle internal and external appeals, and IT and other system changes. As our administrative costs rise, our premiums become more expensive, reducing our market competitiveness and leading to membership losses.
- From MVP's standpoint, the formulation, review, and maintenance of prior authorization policies require a delicate balance. Establishing a new policy or continuing an existing one must provide a substantial return on investment relative to its administrative costs or be justified by safety and quality considerations.
- Reflecting this approach, MVP has removed numerous prior authorization policies in recent years. We strive for thoughtfulness and collaboration when establishing new policies, mindful of all the factors previously mentioned.
- We also make a concerted effort to minimize the demands on providers by requesting only the essential information needed for decision-making.
- Finally, we recognize that automation and innovation in data sharing and integration offer significant opportunities to reduce the current administrative complexity and associated costs within the system.

H.766 Prior Auth Provisions – Bill Language Comments

MVP generally supports the bill's provisions on prior authorization and offers the following observations:

- Section 3 proposes reducing the decision timeframe for urgent prior authorization requests from 48 to 24 hours. MVP has no objections to this change since we already comply with a 24-hour standard for prescription drug coverage in Vermont.
- Section 3 would ensure any authorization remains valid for the duration of the prescribed or ordered treatment, or one year, whichever is longer. MVP currently honors prior authorization decisions for one year, so we support this change. However, a technical suggestion would be to remove "whichever is longer," to better align the

authorization period with the prescribed standard of care for a course of treatment or one year. This is because certain treatments (e.g. antibiotics or Hepatitis C treatments) may not be clinically appropriate beyond a specific timeframe. We should not authorize treatments for an extended period if the standard course of treatment does not warrant it.

- Section 3 would require coordination for approved treatments when a member transitions to a new health insurer. Ensuring continuity of care is crucial for patients, and MVP certainly supports this provision's intent. Further discussion will be needed around effective implementation. We should aim to circumvent any excessively complicated processes that inadvertently increase the burden on providers and members.
- Section 4 instructs the Department of Financial Regulation to establish guidelines that would prohibit prior authorization for any generic medications and for any service that exhibits low variation among providers and denial rates below ten percent across carriers. MVP already does not require prior authorization for covered generic medications. Nevertheless, we challenge the "less than 10 percent" threshold as unworkable in practice and recommend additional dialogue to determine best approach. For example, service volumes fluctuate and differ among carriers. For policies involving high-cost drugs or treatments for rare conditions, the volume often is inherently low and not statistically meaningful. Additionally, there might be quality or safety justifications for requiring authorizations for certain services, regardless of their volume.

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