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January 24, 2024

Representative Lori Houghton, Chairwoman of the
House Committee on Health Care
115 State Street
Room 42
Montpelier, VT 05633

RE: AHIP Comments on Prior Authorization

To Chairwoman Houghton and Members of the Committee on Health Care,

America's Health Insurance Plans (AHIP) appreciates this opportunity to provide comments on H.766, legislation that would update prior authorization and step therapy requirements, health insurance claims, provider contracts, and the collection of cost-sharing amounts.

AHIP and its members are aligned with the Committee's commitment to increase access to high-quality, affordable health care for everyone in Vermont. We believe these goals are best achieved when the regulations and policies are not overly restrictive, ensuring policies do not inadvertently harm patient safety and increase health care costs for all patients.

With this in mind, we respectfully provide you with the below information on how health plans use Prior Authorization (PA) as an important tool to ensure safe, effective, and evidence-based care for patients and to help prevent over-utilization perpetuated by fraud. We hope that AHIP can be a resource for you as the Committee considers legislation that impacts the ability for health carriers to employ utilization management tools while providing access to care producing high quality outcomes.

Direct Billing

We have concerns with Section 7 of the bill, which not only requires health insurance providers to collect cost-sharing from enrollees for covered services, a responsibility currently held by health providers, but also prohibits insurers from recouping non-payment through premium increases or by lowering provider reimbursement. Additionally, the Section prohibits insurers from terminating a plan for nonpayment of cost-sharing. These provisions may destabilize the health care markets and jeopardize health care access for Vermonters. As a result, we ask the Committee to remove Section 7.

Direct billing requirements interfere in the relationship between insurers, patients, and providers and fundamentally alters the way health care services are provided and paid, likely resulting in consumer and provider confusion and potentially large increases in administrative costs.

Section 7's Fundamental Alteration of Health Care Payment Structures May Destabilize Health Care Markets and Adversely Affect Access to Health Care

The use of cost-sharing – co-payments, co-insurance, and deductibles – has been a long-standing and established part of our healthcare system. It is the patient's share of their medical expenses. From Medicare to the fully insured market, cost-sharing has been used to help ensure patients are engaged in their health care decisions as well as assisting them in making informed and price-conscious choices. Patient out-of-pocket costs often function as an incentive for individuals to seek providers and shop for

services that offer efficient, cost-effective care. Eliminating the patient's responsibility to share in that cost at the point of service, and transitioning the responsibility to insurers after the fact, could have an adverse impact on overall health care costs.

Section 7 not only interferes in the contractual relationship between an insurer and provider, but as a practical part of the collections process, patients are currently more likely to pay the provider prior to, or at the point of service, rather than pay a health plan or insurer months after the service has been provided. Most consumers are familiar with the process where monthly premium payments are due to the health plan/insurer, most often provided through their employer, and cost sharing (co-pays, deductibles, coinsurance) are owed directly to the provider.

Increased Administrative Burden for Insurers and Providers

Adopting Section 7's fundamental change in our health care system would not only require a costly build by insurers but would also result in substantial consumer confusion and an unknown loss in revenue. Between the technological and workflow changes and the costs of hiring and training a new workforce on these changes, the long-term cost impact would be significant. In a time where we are looking to policies that reduce administrative burden and seek to streamline and simplify workflows, direct billing would do the opposite.

In addition to causing confusion for patients, this provision is likely to cause providers to adopt new administrative processes for submitting claims and billing. H. 766 extends to the insurance markets that the State regulates, and therefore will not affect all patients. Providers will need to have two systems of billing – one for those patients covered by state regulated plans, and one for everyone else. Further, they would have to differentiate which type of plan a patient has at the point of service and determine then whether they should be collecting cost-sharing. Section 7 will likely cause unnecessary abrasion between carriers and their provider partners.

Extensive consumer education would be needed to ensure that patients understand this fundamental shift in payment. Such a drastic change could cause unnecessary confusion and frustration for patients when seeking and paying for their medical care.

Restricted Ability of Carriers to Recoup Cost-Sharing from Patients

Lastly, Section 7 does not address how plans and insurers would, and are permitted to, recoup any potential losses if a patient does not pay the share of cost – instead, it exacerbates this issue and prohibits reasonable means of recourse for nonpayment. Depending on the percentage of losses, this shift could have a sizeable impact on the amount of funds collected to cover patient claims. Prohibiting insurers to build the cost of the increased administration costs and potential losses into rates is inconsistent with responsible rate development and review processes. Rates are developed based on actuarial principles that consider several factors beyond anticipated medical costs related to the benefit structure developed by the plan. Prohibiting plans from developing actuarial rates would misalign rates with benefits, and plans could wind up in financial jeopardy. This kind of activity would destabilize the health care markets and may ultimately limit health care choice for Vermonters.

As Vermont continues to focus on health care affordability, we also encourage the Committee to do an independent study of the section to analyze and determine its cost impacts on Vermont's health care system. The study should also consider how much hospitals should reduce the fees they are charging if they no longer have the administration of collecting consumer cost sharing. If we are seeking to lower overall health care expenditures, and there is a savings amount for hospitals not to collect consumer cost-shares, should we not know what that number is?

We thus request the Committee to strike Section 7 in its entirety. It is important to note that currently no state has passed direct billing provisions, with recent, similar efforts in California[1], Colorado[2], Maine[3], and New York[4] failing to even receive a floor vote due to cost considerations.

Prior Authorization and Utilization Management Tools

Our concerns with H766's effects on health care accessibility also extends to increased restrictions on prior authorization.

PA is used when there are clinical deviations and is needed to prevent potential negative impacts. An AHIP clinical appropriateness project with Johns Hopkins found that almost 90% of health care providers in the study provide care consistent with evidence-based standards of care.[5] When needed, PA is a proven tool to ensure patients get the most up to date evidence-based care. Health insurance plans continue to collaborate with health care providers and other stakeholders to implement innovative solutions to improve the prior authorization process. However, thirty percent of all heath care spending in the United States may be unnecessary, and in many cases harmful to patients. Indeed, every year low-value care costs the U.S. health care system $340 billion. In addition, providers also want to ensure patients are getting proven, high value care. Eighty-seven percent of doctors have reported negative impacts from low-value care.

Prior Authorization Is Critical to Ensuring Safe, Effective, and Cost-Efficient Health Care for Patients.

Health insurance plans are focused on ensuring that patients get the right care, at the right time, in the right setting, and covered at a cost that patients can afford. Insurers are uniquely positioned to have a holistic view of a patient's health care status and thus use PA as an effective tool that helps to lower a patient's out-of-pocket costs, protects patients from overuse, misuse or unnecessary (or potentially harmful) care, and ensure care is consistent with evidence-based practices before care is delivered.

When providers and plans work together, the patient benefits with better outcomes and less financial burden. Health insurance carriers continue to innovate and collaborate with providers and other stakeholders to implement solutions to promote evidence-based care and improve the prior authorization process. Examples include:

- Streamlining prior authorization for complete courses of treatment for musculoskeletal and other conditions.
- Promoting electronic prior authorization requests and decisions.
- Providing feedback to health care providers on their performance relative to their peers and professional society guidelines.
- Waiving prior authorization for providers with a demonstrated track record in practicing evidence-based care.

PA also promotes the appropriate use of medications and services by helping to confirm that they do not interfere with other types of medications or potentially worsen existing conditions. This includes verifying that medications are not co-prescribed that could have dangerous, even potentially fatal, interactions. Additionally, PA helps to ensure that medications and treatments are safe, effective, and appropriate.

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[1] California SB 250 (2021-2022). https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB250.
[2] Colorado SB20-005 (2020). https://leg.colorado.gov/bills/sb20-005.
[3] Maine LD 530 (2021). https://legislature.maine.gov/billtracker/#Paper/SP0217?legislature=130.
[4] New York 2023 Executive Budget Proposals on Health Care. https://www.governor.ny.gov/programs/fy-2023-new-york-state-budget.
[5] *Clinical Appropriateness Measures Collaborative Project.* America's Health Insurance Plans. December 2021. https://www.ahip.org/documents/AHIP_AppropriatenessMeasures_2022.pdf.

Furthermore, it provides guardrails to help ensure that drugs and devices are not used for clinical indications other than those approved by the Food and Drug Administration or those that are supported by medical evidence. And finally, it helps ensures that patients with a newly prescribed medication or course of treatment will receive accompanying services such as counseling, peer support, or community-based support, as appropriate.

The use of PA is based on evidence-based medical criteria developed by nationally recognized entities. One study shows that the amount of medical knowledge ***doubles every 73 days***.[6] And according to another study from the Journal of Internal Medicine, primary care providers would have to practice medicine for nearly 27 hours per day to keep up with the latest guidelines.[7] Thus, PA helps providers ensure they are adhering to the most up-to-date evidence-based standards.

Even with these fast-paced innovations, health insurance carriers use PA sparingly, with the percentage of covered services, procedures, and treatments requiring PA around less than 15%.[8] Of that, health insurance plans report that up to 30% of PA requests they receive from clinicians are for unnecessary care that is not supported by medical evidence.

Health Insurance Providers Are Committed to Working with Providers to Streamline the Prior Authorization Process.

It is important to note that PA programs are collaborative – health insurance providers use provider input to help ensure treatment plans are protecting patient safety, improving outcomes, and controlling costs. In this spirit, in January 2018, AHIP, together with providers and hospitals, issued a joint consensus statement.[9]

Recent surveys show that health insurance plans are waiving or reducing PA requirements, - between 2019 to 2022, the percentage of plans waiving or reducing PA based on participation in risk-based contracts increased from 25% to 46% for medical services, and from 5% to 8% for prescription medications.[10]

We applaud the promotion of electronic authorization (ePA) per the legislation, but this will only work when providers are also included in this transaction to ensure that the program is as effective and efficient as possible. For instance, even though almost all health insurance carriers offer ePA, 60% of PA requests for medical services are still being submitted manually by providers, and over a third of PA requests for medications are submitted manually.[11]

In January 2020, AHIP along with two technology partners and several member insurance providers, launched the Fast Prior Authorization Technology Highway (Fast PATH) initiative to better understand the

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[6] Densen, Peter. *Challenges and Opportunities Facing Medical Education*. Transactions of the American Clinical and Climatological Association 2011. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3116346/.
[7] Porter J, Boyd C, Skandari MR, Laiteerapong N. *Revisiting the Time Needed to Provide Adult Primary Care.* Journal of General Internal Medicine. January 2023. https://pubmed.ncbi.nlm.gov/35776372.
[8] *Prior Authorization: Selectively Used & Evidence-Based: Results of an Industry Survey.* America's Health Insurance Plans. https://www.ahip.org/wp-content/uploads/Prior_Authorization_Survey_Infographic.pdf.
[9] *Consensus on Improving the Prior Authorization Process*. American Hospital Association, America's Health Insurance Plans, American Medical Association, American Pharmacists Association, Blue Cross Blue Shield Association, and Medical Group Management Association. Available at https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc-public/prior-authorization-consensus-statement.pdf.
[10] *Improving Prior Authorization Processes: How Health Insurance Providers Are Delivering on their Commitments.* America's Health Insurance Plans. https://www.ahip.org/documents/202207-AHIP_1P_Consensus_Statement_Actions-v02.pdf.
[11] *Id.*

impact of electronic prior authorization on improving the prior authorization process.[12] AHIP's Fast Path study shows:

- Sixty percent of experienced users (providers) said electronic prior authorization made it easier to understand if prior authorization was required.
- The median time between submitting a prior authorization request and receiving a decision from the health plan was more than three times faster, falling from 18.7 hours to 5.7 hours in processing time – a 69% reduction.

As plans continue to take additional steps with encouraging ePA, the 2019 CAQH (Council for Affordable Quality Healthcare) Index conducted a study to measure progress in reducing the costs and burden associated with administrative transactions exchanged across the medical and dental industries.[13] During this study, CAQH found of the $350 billion dollars spent on healthcare administrative costs in 2019, $40.6 billion was spent on administrative transactions and the health care market could have saved $13.3 billion by automating utilization management tools. Therefore, AHIP recommends stakeholders consider exploring available pathways to increase provider adoption of electronic prior authorization technology.

Additionally, we are concerned with Vermont's broad proposal to create gold carding requirements.

> ***Broadly waiving PA and mandating gold carding programs could lead to clinically inappropriate care, exposing patients to potential harm by using a service or drug where there is little to no evidence of clinical benefit, and could raise costs for all consumers and purchasers.***

Patients should expect to receive safe and appropriate care 100% of the time, period. Prohibiting PA eliminates checks on unnecessary care – as previously mentioned, health insurance carriers report that up to 30% of PA requests they receive from clinicians are for unnecessary care that is not supported by medical evidence.[14] This in turn will significantly limit a carrier's ability to ensure health care dollars are used most efficiently to produce high quality health outcomes, effectively ending provider accountability for fraud, waste, and abuse.

Eliminating PA by mandating broad gold carding programs will significantly and negatively impact Vermont's health care system. Through Texas' experience with the implementation of its gold carding law, HB 3459 which passed in 2021, we now have a better picture of these impacts. ***The law is estimated to increase premiums for small businesses and individuals by more than $1 billion annually in the fully insured market alone.[15] Just one health plan estimates that the gold carding mandate will cost consumers $500 million a year to end prior authorizations – a figure that is estimated for just its members.[16]***

Another Texas plan used back surgeries as an example of a procedure that is a high-cost intervention for medical issues that could potentially benefit from less extreme, and more affordable, care delivery approaches to highlight the cost impacts of the gold carding mandate.[17] Under the law, employers would have to pay 100% back surgeries, even though they are inappropriate at least 10% of the time. ***The claims for this one procedure alone would cost the plan $150 million a year.***

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[12] *Prior Authorization: Helping Patients Receive Safe, Effective, and Appropriate Care.* America's Health Insurance Plans. https://www.ahip.org/prior-authorization-helping-patients-receive-safe-effective-and-appropriate-care.
[13] *2019 CAQH Index.* CAQH. https://www.caqh.org/news/caqh-2019-index-133-billion-33-percent-healthcare-administrative-spend-can-be-saved-annually.
[14] *Prior Authorization: Helping Patients Receive Safe, Effective, and Appropriate Care.* America's Health Insurance Plans. https://www.ahip.org/prior-authorization-helping-patients-receive-safe-effective-and-appropriate-care.
[15] *Veto Letter Request to Governor Abbot on HB 3459.* Texas Association of Health Plans. June 3, 2021.
[16] *Id.*
[17] *Id.*

Furthermore, a Miliman study found that eliminating PA could increase premiums by $20.1 - $29.52 PMPM – a total increase of $43 - $63 billion annually in the commercial market nationwide.[18] A separate Milliman study, specifically looking at Massachusetts, predicts the elimination of PA to increase premiums from $51.19 - $130.28 PMPM. One key factor for these huge increases is due to the elimination of the Sentinel Effect on providers[19]. When providers know they are being monitored, their performance tends to improve. Removing PA cuts out the one party that has the fullest view of patient care and that understands contraindications. As a result, health insurance providers have reported increased utilization when gold carding programs are put into place.

Last week, the Centers for Medicare & Medicaid (CMS) released the Advancing Interoperability and Improving Prior Authorization Processes final rule which requires plans in federal programs to build and maintain three new application programming interfaces (APIs): 1) to enable electronic prior authorization, 2) to share large-scale population health data files with providers for value-based care, and 3) to support coordination of care when a patient moves from one payer to another. Industry and health care stakeholders are in the process of analyzing this nearly 900-page rule. We look forward to having additional discussions through our state partners on this important development.

Gold Carding

We are also concerned about the administrative difficulties of operationalizing gold carding programs which causes further confusion and frustration for providers and patients. Again, using Texas as an example, while the law had an effective date of January 1, 2022, implementation was delayed due to a particularly cumbersome rulemaking process.

Section 4 of the bill instructs the Department of Financial Regulation to adopt rules, bulletins, or other guidance necessary that would effectively an incredibly broad gold carding program for any health care service with approval rates of 90% or greater. Gold carding programs are most effective when provider performance is closely monitored because they are not appropriate for all providers and all services. Gold carding programs should:

- Be targeted to specific services and where provider performance can be regularly reviewed.
- Separate out prescription benefits from the medical benefits to allow for more tailored review processes and allow health plans and their PBM partners to fully utilize the safety and efficacy tools already in place to protect patients and consumers from harmful and costly drugs.
- Allow health insurance providers to monitor providers participating in these programs to ensure that the provider's standard of practice is consistent with the standard of safe, timely, evidence-based, affordable, and efficient care.
- Allow insurers to revoke a provider's participation in a gold carding program if a provider is not following those standards.[20]

These guardrails are necessary to ensure that providers who receive gold card privileges continue to deliver consistent patterns of high performance to the patients they serve. Health insurance carriers thus need flexibility in operationalizing these programs to keep up to date with medical and safety innovations.

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[18] Busch, Fritz S., and Stacey V. Muller. *Potential Impacts on Commercial Costs and Premiums Related to the Elimination of Prior Authorization Requirements*. Milliman Report. March 30, 2023. https://www.milliman.com/-/media/milliman/pdfs/2023-articles/8-18-23_bcbsa-prior-authorization-impact.ashx.

[19] Busch, Fritz S., and Peter Fielek. *Potential Impacts on Costs and Premiums Related to the Elimination of Prior Authorization Requirements in Massachusetts*. Milliman Report. November 29, 2023. https://www.milliman.com/-/media/milliman/pdfs/2023-articles/11-29-23_mahp-prior-authorization-impact.ashx

[20] *New Survey: Effective Gold Carding Programs are Based on Evidence and Value for Patients.* America's Health Insurance Plans. July 19, 2022. https://www.ahip.org/resources/new-survey-effective-gold-carding-programs-are-based-on-evidence-and-value-for-patients.

Thank you for your consideration of our comments. AHIP and its members stand ready to work with Vermont on this critical issue. If you have any questions or concerns regarding our comments and would like to discuss these matters further, please contact Sarah Lynn Geiger at slgeiger@ahip.org or by phone (609) 605-0748.

Sincerely,

Sarah Lynn Geiger, MPA
Regional Director, State Affairs