BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association.

BERLIN HQ
445 INDUSTRIAL LANE
BERLIN, VERMONT 05641

P.O. BOX 186
MONTPELIER
VT 05601-0186

800 247 2583
800 922 8778
802 255 4550

February 14, 2024

Representative Houghton, Chair
Representative McFaun, Vice Chair
Representative Black, Ranking Member
Representative Berbeco
Representative Carpenter
Representative Cina
Representative Cordes
Representative Demar
Representative Farlice-Rubio
Representative Goldman
Representative Peterson

Dear Members of the House Health Care Committee,

Below are our comments on **H.766 An act relating to prior authorization and step therapy requirements, health insurance claims, and provider contracts – HHC Committee Draft 2.1**

Section 1 - Step Therapy

This section severely restricts the ability to use Step Therapy protocols that require patients to try therapeutically equivalent, less expensive drugs to treat their condition when clinically appropriate before approving higher-cost brand and specialty drugs. **These sections will increase prescription drug spending by $6.2 million for Blue Cross VT members including health plans for teachers that will impact property taxes.**

Blue Cross VT employs Step Therapy as one tool to control prescription drug costs. Overall, prescription drugs comprise approximately 35% of health insurance premiums. Total retail prescription drug costs for our members grew 24.9% between 2022 and 2023. The majority of the costs are concentrated in a few high-priced drugs for a small number of members. Specialty drugs comprise 1.7% of all prescriptions but account for 55% of overall drug spending and therefore are the focus of our cost-containment efforts and require patient-specific approaches to lower costs without causing adverse impacts.

Section 2 – Claims Edits

Health insurance plans are obligated to review claims submitted by providers for accuracy and correct billing for the care provided. Members and employers expect their health plan to ensure that the bills for their care are appropriate. Claims editing catches mistakes, along with more serious coding issues, while applying consistent industry standards. Limiting outpatient and professional to only Medicare NCCI edits and facility claims to Medicare Code Editor edits in section (b) severely restrict a health insurer's ability to employ commonly accepted national standards for reviewing claims. This significantly narrows the ability for health plans to edit claims and excludes all of the providers and services not covered by Medicare and as written, eliminates all edits for pharmacy claims unless approved by the DFR Commissioner. **This is expected to increase bills for Blue Cross VT members by millions of dollars. Pharmacy edits alone account for $52 million dollars in adjustments. Initial estimates indicate that at least $24 million, but likely more, of medical code edits will be eliminated due to these limitations.**

Examples of claims edits Blue Cross VT would be prohibited from employing include:

- Denying the same codes billed multiple times for the same services by the same provider on the same date for the same patient
- Denying separate services when a global obstetrical package for uncomplicated maternity is billed, on the same day as the delivery
- Denying procedures that are inconsistent with the patient's age based on the code definition (example newborn services on a person over age 65)
- Denying emergency visits when they are billed in any place of service other than the Emergency Department
- Limit reimbursement of diagnostic tests and radiology services to no more than the amount for the global service
- Limit claims to the number of units that exceed the assigned allowable unit

The changes to the means of communication for provider notifications, the quarterly dates for implementing coding edits, and the working group modifications are acceptable to Blue Cross VT.

The new language in (e) on "prepayment coding validation edit" will prohibit the use of prepayment review that requires documentation prior to claims adjudication, with the specific exceptions noted. **These changes are expected to result in an additional $6.4 million in higher payments by patients and customers through increased out-of-pocket expenses and premiums.**

Section 3 & 4 – Prior Authorizations

Section 3 – Prohibits commercial insurers from imposing any prior authorization requirement for any admission, item, service, treatment, or procedure that is more restrictive than the requirements of VT Medicaid. The only exceptions are for pharmacy, out-of-network, and services not covered by VT Medicaid. This section is effective on January 1, 2025 and will allow, at best, just over six months to completely change every medical policy, every payment policy, every prior authorization, and re-program the entire claims process system for admissions, items, service, treatment or procedure that are more restrictive than the requirements of VT Medicaid.

VT Medicaid is a completely separate government payer that operates under different federal and state laws, has unique coverage and benefits, no premium requirements, is funded through federal and state taxpayer resources, and does not negotiate payment rates with providers. Blue Cross VT is unable to determine with any accuracy the full scope of the administrative and financial impact of this section of the bill.

A superficial review indicates that VT Medicaid does not even have corresponding billing codes for 327 of the codes for which Blue Cross VT requires a prior authorization and it appears that there are 310 codes that VT Medicaid requires a prior authorization where Blue Cross VT does not. Reviewing each of these differences will take time and research to understand the differences.

For illustrative purposes, VT Medicaid has eliminated most of the prior authorization requirements for imaging services and requiring Blue Cross VT to align with these medical policies is expected to have a significant financial impact. Blue Cross VT typically pays 5-15 times the price for these imaging services as VT Medicaid.

EXAMPLE MRI BRAIN STEM W/O & W/DYE (70553)

- Average Price Per MRI Blue Cross VT = $4,386
- VT Medicaid Pays $283.05
- Blue Cross VT pays on average 15.5 times what VT Medicaid pays for a single MRI

The prices paid for services at Blue Cross VT and those paid by VT Medicaid are incompatible with aligning decisions. It is unrealistic to ask our health plan to cede important decisions about the appropriate use of prior authorization and medical policies to an unrelated entity. **These proposals collectively could increase member costs by up at least $11.5 million and does not include estimates for increased utilization.**

Examples of prior authorization protecting patients – in both of these instances the procedures were covered by the state's Medicaid programs:

They Lost Their Legs. Doctors and Health Care Giants Profited. New York Times, July 15, 2023. (arthectomies)

A New York Hospital Pushed Weight Loss Surgeries on Prisoners, And Left Some Malnourished Report Says, Business Insider December 10, 2023 (bariatric surgery)

Section 4 (A) and (B) shortens the timeline for approval of urgent prior authorization requests from 48 to 24 hours and the timeline for non-urgent prior authorization within two business days. (Note: There is never prior authorization for any emergency treatment.) These changes would be effective January 1, 2025 except for when there is a technology upgrade required.

Section 4 (D) and (E) – Prior Authorizations

(D) requires that prior authorizations for the duration of the course of treatment, or one year, whichever is longer.

This is particularly impactful for prescription drugs. It may not always be appropriate to have a prior authorization in effect that is longer than the course of treatment. Most drug prior authorizations are one year in length, but some are shorter, between 3-9 months. Reauthorization criteria is based on the tolerance and efficacy of the drug and the medical necessity to continue.

One example are the costly drugs used to treat Hepatitis C. Epclusa, is only indicated for a 12-week course of treatment. In addition, these drugs have higher than the average number of drug interactions, and patients should be evaluated closely if they have cirrhosis, co-existing hepatitis B infections, a prior liver transplant, or are pregnant. Allowing a prior authorization for one year increases the possibility of patients taking their medications beyond the prescribed timeframe and poses additional risks.

Suggested revised language: Prior authorization approval for a prescribed treatment, service, or course of medication should be approved for a minimum of 1 year unless this is a first-time treatment, the treatment is indicated for less than 1 year, or the ordered course of treatment is less than 1 year.

(E) Requires that a health plan allow a member 90 days to continue a drug that was approved for coverage under a previous health plan.

This extends from the typical two weeks to three months the amount of time available for a new health plan member to obtain a prior authorization for prescription drugs. In most instances, the patient benefits from obtaining a prior authorization more expediently and gives the health plan the ability to employ cost saving tools where appropriate. Blue Cross VT already extends prescriptions to members who require additional time to obtain a prior authorization. **The three-month delay will increase costs by 25% in the instances where the prior authorization process results in cost savings.**

Policies, Manuals and Notices

Blue Cross VT supports clear notice and communication between payers and providers. The provisions added in H.766 are excessively proscriptive and will make the process slower and more burdensome for both parties.

Section 6 – Reducing Administrative Burdens Working Group

Blue Cross VT recognizes that increasing requirements for patient cost-share has placed additional burden across the health care system – on patients, providers, health plans and third-parties who are all involved in these complicated interconnected financial processes that this working group can seek to address. Cost-sharing is a federally-mandated component of Affordable Care Act standard plan designs through the Actuarial Value (AV) requirements and grows at the rate of medical cost growth in order to balance the premium and out-of-pocket factors of the equation.

Blue Cross VT represents the 220,000 Vermonters who purchase commercial health insurance and are our members and customers. These people are asking us every day why their health care costs are so expensive and continually increasing. They want their bills to be lowered, not raised by the millions of dollars that will be the result of the changes in H.766.