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Chairwoman Ginny Lyons
Senate Committee on Health & Welfare
Via-email

Dear Chairwoman Lyons and members of the Senate Health & Welfare Committee,

Thank you for the opportunity for Cigna Healthcare to provide comments on H. 766. Cigna weighed in throughout the House Committee process for this bill and still has some remaining concerns. Several of the processes under discussion in this bill play a critical role in helping to ensure that patients receive appropriate, quality care at a price that is affordable to members and employers, and therefore we urge you to consider potential unintended outcomes for Vermonters should the bill move forward in its current form.

Section 2

Limitations on claims edits are problematic. Prepayment review is a necessary component of claim adjudication when more information is needed to process a claim and determine reimbursement. Prepayment review is done during adjudication but prior to reimbursement and helps avoid potentially unnecessary healthcare costs. Limiting a carrier's ability to implement policy changes related to proper and correct coding limits our ability to ensure that members are only being billed and paying for appropriate charges. Legislation should not limit a health plan's ability to ensure that our members are utilizing the most appropriate and cost-effective care. These limitations reduce the quality of services approved as medically appropriate and ignore the desire of employer groups to focus on cost containment programs as a necessary component of claim payment accuracy and reimbursement.

While we appreciate the need by providers to have notice of changes in accordance with state regulations, review and approval of edits by a regulator is not common, would limit our ability to operate effectively and should not be required. We continue to respectfully request that this provision be removed, at least until the proposed working group has an opportunity to hear from all stakeholders.

Section 3 & 4

Prior authorization promotes better health outcomes, lowers costs for patients and is an important tool that employers choose to combat premium inflation for employees (VT residents). Among other important benefits, precertification prior to services being provided allows Cigna the opportunity to confirm the patient's eligibility and available benefits based upon the current enrollment information; confirm the medical necessity of the proposed services; and evaluate the proposed setting and level of care to determine if it is clinically sound, safe and cost effective.

While eligibility, available benefits, and medical necessity can be determined after the service is provided, the failure to prior authorize denies Cigna the opportunity to effectively engage in other aspects of the precertification process which are designed to assist our customers to have access to high quality and cost effective care in the most appropriate setting.

And while we can appreciate the sentiment that "providers know best", it is critical to understand that medical knowledge is growing at unprecedented rates and accelerating every year. This creates knowledge gaps for even the most talented physicians. Prior authorization ensures that evidence-based clinical guidelines are applied to providers' requests to make sure they're in line with current medical science and best medical

practices, which helps make sure patients receive the optimal treatment at the optimal site based on their individual diagnosis and prognosis.

Aligning commercial plan prior authorization to the Vermont Medicaid program is problematic for several reasons. It would be extremely challenging to incorporate and maintain alignment with the Medicaid code list and fee schedules. Additionally, it is unclear if the Vermont Medicaid program would be able to keep pace with high-paced innovation areas like specialty (particularly oncology) medications and laboratory testing. This could essentially force adherence to policies that will frequently be outdated and expose patients to clinical risk and harm simply because they cannot be maintained. Prior Authorization enables members/patients to receive the most up to date evidence-based care. Limiting tools, such as prior authorization, that are used to manage health plans and associated costs negatively impacts employers' ability to develop flexible plan designs and better meet the needs of specific employee populations.

If Vermont Medicaid was slower than the commercial plans to add something to the precertification list or slow to update criteria, the financial impact to a plan could be significant for a single service (for example, gene therapy). We respectfully request that the committee remove this alignment provision until the potential impact is better understood. If there is a critical need to do related legislation this session, we would suggest looking at alternatives that focus on appropriate clinical criteria, and we would be happy to discuss alternatives seen in other states with you.

Regarding turnaround times, I would ask your consideration of the potential unintended consequence that further shortening turnaround times may have which is to increase denials. Additionally, I'd note that the CMS Interoperability and Prior Authorization Final Rule recently issued generally shortens the turnaround time for responses to prior authorization requests to 7 days for standard requests and 72 hours for urgent requests. Regardless, it is important that any requirements related to turnaround times should require the receipt of all necessary clinical information and we appreciate that this appears to have been included in the revised language.

While limiting prior authorization to only once annually is concerning in some instances (if for example, a course of treatment has a much shorter timeframe), the new language in Section 4 (D) that prohibits prior authorization for five years on any treatment, service or course of medication that continues for more than one year is even more problematic. A 5-year approval is not practical or clinically appropriate and the standards of care can change over 5 years. With this new provision, patients could miss opportunities for better and more appropriate care.

Prior authorization is an important and valuable tool in health care. For our part, we support that clinical review criteria be evidence-based and generally accepted as the standard of care and that there be transparency around what services require prior authorization. In line with what other Vermont carriers have already shared, Cigna provides information on its website regarding what services require prior authorization. We also support continuity of care provisions where appropriate and support the continued advancement of prior authorization automation as a solution to address many of the perceived challenges related to the prior authorization process.

Sections 5

Policies and manuals are well-established mechanisms for communicating evolving coverage and reimbursement standards. Contracts between Cigna and network providers specifically state that the provider agrees to abide by Cigna's administrative guidelines (including coverage and reimbursement policies) as a condition of participating in our network. Administrative guidelines are used, in part, to adopt emerging industry standards, and to administer our client benefits more accurately with the advent of new technology and processes. Cigna agrees to provide advance notice of material changes to Administrative Guidelines, and the provider has the right to terminate the agreement if they object to a change in the Administrative Guidelines. This allows the parties' relationship to evolve with changing coverage and reimbursement

policies without having to continually amend contracts. Giving providers the ability to regularly halt implementation of policies will severely compromise Cigna's ability to administer client accounts in step with emerging industry practices, hamper innovation, limit Cigna's ability to meaningfully keep pace with industry and clinical developments, and avoid related savings in the health care system.

Administrative guidelines are often used to communicate new reimbursement policies, such as billing protocols for new services. They are also used to inform providers of new coverage policies that align with customer certificates and benefit plans. **Administrative guidelines are not, and cannot, be used to make changes to customer insurance certificates or negotiated reimbursement rates with providers. It is important to recognize that in the event of an inconsistency between the provider contract and the administrative guidelines, the provider contract controls.** The practice of allowing changes through administrative guidelines is a well-established and transparent process. It provides for advance notification of any changes, a portal to pull information from and a point of contact if any questions arise from providers. Administrative guidelines and provider manuals are the key to communicating beneficial changes in a rapidly evolving health care field. We have an obligation to constantly pursue options that improve the quality of, and access to, care.

Section 7

I recommend that if these reporting provisions remain in the bill, the health plan reporting should be coordinated through the Department of Financial Regulation to ensure clear direction of expectations to health plans and consistency among the reports. I'd also similarly request that the reporting requirements for providers be required to the same extent it is of the health plans and suggest that the Green Mountain Care Board coordinate that request for clarity and consistency.

We hope you will consider the negative impact this legislation could have on the health care system as whole, but most importantly on Vermont customers and patients. Thank you for the opportunity to submit these comments for your consideration. If you have any questions, please do not hesitate to contact me at (804.904.3473) or Christine.Cooney@cignahealthcare.com.

Sincerely,

Christine M. Cooney

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