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Chairwoman Lori Houghton
House Committee on Health Care
Via-email

Dear Chairwoman Houghton and members of the House Committee on Health Care,

Thank you for the opportunity for Cigna Healthcare to provide comments on H. 766. While I have other concerns with the bill, I will limit my comments today to the provisions regarding prior authorization restrictions and what appears to be a gold carding provision. I would first like to explain the purpose and benefit of prior authorization or precertification. 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.

Section 4 of the bill appears to propose what is often referred to as "gold carding". Gold carding is built on a flawed premise – asking patients to accept that even the best providers will get their care wrong (in this case) 10% of the time and remain completely unchecked resulting in unnecessary out-of-pocket costs for members, delayed access to evidence-based care, and exposure to potentially harmful care. Our experiences have shown gold carding results in serious negative impacts to employers and patients. The achievement of a certain approval rate, as required for gold carding, is no guarantee of future accuracy in the absence of a utilization review program. Removing incentives like utilization review causes a regression in behavior because of the misaligned incentives that are inherent in a fee-for-service reimbursement environment. This regression decreases the quality of patient care and increases costs for everyone.

Medical knowledge is growing at unprecedented rates and accelerating every year. This creates knowledge gaps for even the most talented physicians. Additionally, having deep knowledge and experience in one clinical area does not always translate to other areas. For example, a neurologist may be very competent in using brain MRI procedures to assess patients with a headache but not as experienced in using a joint MRI to assess a patient with knee pain. For providers who qualify for gold carding, there is no opportunity to help fill these gaps in knowledge, which is a great disservice to patients. 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. Gold carding threatens these outcomes. Additionally, utilization review creates a sentinel effect whereby performance improvement occurs because providers in a program know they are being evaluated. Without utilization review, this improvement dissipates.

Regarding turnaround times, I would encourage you to consider 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 issued this week generally shortens the turnaround time for responses to prior authorization requests to 7 days for standard requests and 72 hours for urgent requests which appears more generous than the current Vermont law. Regardless, it is important that any requirements related to turnaround times should require the receipt of all necessary clinical information.

We hope you can appreciate the value that prior authorization has 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. We also appreciate continuity of care provisions where appropriate.

And last, but not least, it's important to support the continued advancement of prior authorization automation as a solution to address many of the perceived challenges related to the prior authorization process.

Thank you for the opportunity to submit 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,

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