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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 additional comments on H. 766. While I have previously provided comments on the provisions regarding prior authorization restrictions, I'd like to share thoughts here on other provisions of the bill including those related to health insurance claims, provider contracts, and the collection of cost-sharing amounts. 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 these proposed changes should be carefully examined for unintentional outcomes.

Section 2

Regarding the language on claims edits, limiting edits to once a year is problematic for numerous reasons. 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. It is a bit unclear what the intent of this language is. If the bill is proposing that prepayment review cannot be required as a routine process for all claims prior to claim adjudication, it would be helpful to clarify that. However, if the bill intends to mean that prepayment review cannot be required until after adjudication, the only options would be to pay as billed without question (which pays potentially unnecessary costs ultimately driving up healthcare costs) or to deny the entire claim if more information is needed, which essentially increases processing time, requires resubmission, and delays potential payment.

It is important to understand that proposals like this limit a carrier's ability to implement policy changes related to proper and correct coding meant 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. Additionally, it would not be feasible to implement a year's worth of edits all at once and it would compromise our fiduciary responsibility to manage client spend, service levels, and performance guarantees if we were to delay implementation of needed reimbursement changes. It would 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 respectfully request that this provision be removed.

Sections 5 (D) and 6

The new language in these section requiring policies and manuals to be treated as a contract amendment is extremely problematic and would profoundly disrupt 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. If contract amendments were required every time a guideline changed, or if amendments to the administrative guidelines could not be implemented, Cigna's ability to administer client accounts in step with emerging industry practices would be severely compromised. This would hamper innovation and limit Cigna's ability to meaningfully keep pace with industry and clinical developments.

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.

This legislation would impede an insurer's ability to innovate and adapt as better care develops and would impact our ability to implement policies that align with customer benefit plans. If enacted, this legislation would give Vermont providers the ability to impact the adoption of national coverage and reimbursement policies, would increase the total cost of care, and would require constant negotiation of provider contracts at enormous operational expense.

Additionally, limiting the frequency of requesting medical records is not realistic or practical. Requests for medical records is based on number of claim submissions requiring clinical information/notes upon which reimbursement can be determined. No one can predict the number of times such information may be required during a given period.

Section 7

Requiring health insurance plans to collect cost-sharing from enrollees for covered services is also extremely problematic. This is a responsibility and process currently held by healthcare providers. For a national health plan, to change the process in Vermont and require implementation of an entirely new process would be tremendously challenging, if not impossible, and require significant resources. Rather than go into detailed testimony here, I will say that I agree with the significant concerns as outlined by AHIP in its testimony to the committee dated January 24 regarding this section of the bill.

We hope you will consider the detrimental impact this unnecessary legislation could have on the health care system as whole, but most importantly on customers and patients. Please consider removing these extremely problematic provisions from the bill. 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,

Christine M. Cooney

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