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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 the revised version of H. 766. I appreciate any attempt to solicit feedback from stakeholders on the impact of the proposed provisions in this bill. As mentioned previously, 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

Although we appreciate the change to quarterly, the limitations on claims edits continue to be concerning. As mentioned previously, 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.

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 and would require a more thorough review and impact assessment. 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. 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).

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

Requiring health insurance plans to collect cost-sharing from enrollees for covered services is also extremely problematic. This is a responsibility currently well known to be held by healthcare providers. We appreciate that the committee is taking a workgroup approach as opposed to moving forward with this provision as previously drafted.

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 additional 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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