



Vermont Chapter

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To : Chair Houghton and Members of the House Health Care Committee
From: Jessa Barnard, Vermont Medical Society, jbarnard@vtmd.org
Date: January 25, 2024
RE: Support for H. 766 – Reducing Paperwork Burdens in Health Care

Thank you for the invitation to testify. My name is Jessa Barnard, and I am the Executive Director of the Vermont Medical Society. I am here to testify not only on behalf of the Vermont Medical Society but also the Vermont Academy of Family Physicians, American Academy of Pediatrics Vermont Chapter, and Vermont Psychiatric Association. Our organizations collectively represent approximately three thousand physicians and physician assistants in Vermont. Our members provide primary care and specialty health care services in hospital-based practices, Federally Qualified Health Centers, and independent practices and are here today to urge you to support H. 766, which includes necessary prior authorization reform and a practical solution to insurance claims processing requirements.

Perhaps no other issue garners as much attention and support from our membership as reducing the paperwork barriers that come between them and providing clinical patient care. In the face of overwhelming health care workforce shortages and clinician burnout, reducing prior authorization and billing tasks are two concrete steps the legislature can take to help increase access to care.

Collecting of Cost Sharing by Health Plans (Section 7)

Our organizations support reducing the staff time, overhead expenses and ethical conflicts created by placing practices in the position of collecting patient cost sharing, including deductibles, coinsurance, co-payments. Practices and health care facilities spend enormous staff time and resources chasing patient co-pays or co-insurance, when these costs are in fact a feature created by and designed by health plans, not the health care practices. And you know from your work on H. 721, unfortunately the number of Vermonters who have health plans that can carry high out of pocket costs is increasing. Health plans are already billing patients for their premiums and are the ones with the most accurate and timely information about what a patient owes based on where they are in their plan year and plan design. Further, disputes over cost sharing or a patient's inability to pay puts health care providers in the role of enforcing health plan design in a way that can break a patient's trust in seeing the health care provider. VMS supports health plans collecting these payments directly from patients.

As an independent primary care practice shared with VMS:

Our patient receivables are growing all the time. In our receivables, we have amounts owed from patients that exceed 180 days that are approaching \$1 million. This amount is only since 2018...our last system conversion. We are not optimistic for payment. Collection agencies are also not interested in working on it. In primary care, these amounts tend to be a high volume of accounts with lower amounts due so the agencies conclude it is too much work for the dollar gain. If we could get the payers to be responsible, that would certainly provide some great relief.

The American Medical Association echoes this position. In November, the AMA established new policy supporting the removal of physicians from the middle of cost-sharing between insurers and patients and to require insurers to collect deductibles, copays or coinsurance from patients.¹ According to the AMA, the collection of cost-sharing is a burden on many physicians but it is especially small practices and those in rural areas that tend to be more intensely impacted by the challenges experienced in collecting cost-sharing.

Delegates voted to adopt policy instructing the AMA to “support requiring health insurers to collect patient cost-sharing and pay physicians their full allowable amount for health care services provided, unless physicians opt-out to collect such cost-sharing on their own.”

The AMA Report supporting this position outlines that payers already have tools to provide such services, including InstaMed, Flywire, Zelis, and MedPilot utilized by companies like UnitedHealthcare and Blue Cross Blue Shield.² However, the report also notes that some payers require practices to use such services and then deduct a percent of the payment collected as an “electronic transfer fee” or otherwise reduce payments to the practice – therefore the language in H. 766 prohibiting payers from withholding or reducing payments to practices is critical.

Modifications to Claims Edit Process (Sections 2, 5 & 6)

While not the focus of today’s hearing, VMS also strongly supports sections 2, 5 & 6 of the bill, which would reduce the burden of insurance claims processing. VMS would be pleased to offer additional testimony at a future time addressing these sections of the bill.

Prior authorization

The sections of H. 766 addressing prior authorization largely follow the areas of reform explored by the Department of Financial regulation this fall. **The VMS strongly recommends that the legislature adopt H. 766 and proceed with the four areas of reform as discussed by DFR in their Nov. 22, 2023 memo to the House Health Care and Senate Health and Welfare Committees.**

1. Step Therapy Reform (Section 1)

As DFR described in its memo, “Step therapy is a subset of [prior authorization] “that specifies the sequence in which different prescription drugs are to be tried for treating a specified medical condition....Because step therapy protocols often do not consider a patient’s individual clinical circumstances, they can be highly disruptive— especially in cases where a patient has already stabilized on a drug that is higher on the protocol.”

VMS strongly supports the adoption by Vermont of a clear step therapy override process when a patient is stable on a prescription drug or in other circumstances when it could be detrimental to patient health. Among the important exemptions included in H. 766, Section 1(e)(1)(A) would state that a patient does not have to repeat step therapy if they are continuously enrolled in the same plan and section 1(e)(1)(B)(iv) would allow an override to step therapy if the patient is stable on a medication, regardless of whether it is the same insurance plan.

¹ <https://www.ama-assn.org/press-center/press-releases/ama-house-delegates-adopts-new-policies-interim-meeting#:~:text=Delegates%20voted%20to%20adopt%20policy,%2Dsharing%20on%20their%20own.%E2%80%9D>

² <https://www.ama-assn.org/system/files/i23-handbook-refcomm-j.pdf>.

2. **Decreasing Timeframes to Respond to Completed PA Requests (Section 3 (A) & (B))**
VMS supports reducing the timeframe for insurers to respond to urgent prior authorization requests to 24 hours.
3. **Placing Limitations on Reauthorization (Section 3 (D) & (E))**
VMS supports limitations on how often patients and clinicians are required to seek reapproval for services or medications. These sections are similar to Massachusetts legislation [H. 1143](#) and would:
 - a. Require a PA to be valid for the duration of treatment or at least 1 year; and
 - b. Require insurers to honor the patient's PA from another insurer for at least 90 days.
4. **Expanding Prior Authorization Exemptions/Gold Carding Pilots.**
VMS strongly supports reducing the number of procedures or clinicians subject to prior authorization until such reductions are meaningful enough to be felt in the day-to-day paperwork demanded of clinicians. H. 766 states that carriers could not impose prior authorization requirements for any generic medication or for any admission, item, service, treatment, procedure, or medication, that have low variation across health care providers and denial rates of less than 10 percent across carriers. The intent is to reduce prior authorization consistently between payers. As outlined further below, this would improve upon existing Gold Care programs, which are often not helpful on the ground for reducing the paperwork burden on clinicians.

VMS supports the reforms described above, and the urgent need for a reduction in the paperwork burden on health care clinicians, for the following reasons:

- Vermont is already experiencing a health care professional workforce shortage. **16% of primary care physicians in Vermont are planning to retire or reduce hours** within 12 months.ⁱ We cannot afford to have one more primary care provider retire early or reduce their practice because of paperwork burdens.
- **Prior authorization can decrease access to appropriate care and increase costs:**
 - In a VMS member survey, 94% of respondents believed that the prior authorization process had a negative impact on their ability to treat patients, 81% reported that it is very or extremely difficult to determine when a PA will be required and **43% had made an emergency room or specialist referral to avoid having to go through the prior authorization process.**
 - 64% of physicians in a national survey report that PA has led to **ineffective initial treatments** (i.e., step therapy); 62% of physicians report that PA has led to **additional office visits** and 46% of physicians report that PA has led to immediate care and/or **ER visits.**ⁱⁱ
- **PA is taking clinicians away from patient care, exacerbating wait times:**
 - A 2022 AMA survey reports that **physicians complete, on average, 45 PAs per week** and physicians or their staff spend almost two business days (14 hours) each week completing PAs.ⁱⁱⁱ

- A recent time study revealed that during the office day, **physicians spent 27.0% of their total time on direct clinical face time with patients and 49.2% of their time on EHR and desk work**^{iv}
- **Reducing prior authorization does not increase utilization.** DVHA found that temporary waivers of high-tech imaging prior authorization and prior authorization for DME, supplies, prosthetics, and orthotics during the COVID-19 public health emergency did not increase utilization of services and DVHA has extended these waivers.^v MVP’s pilot gold card program found no additional expense or utilization.^{vi}
- **Our current Vermont efforts to reduce prior authorization are fragmented and inconsistent:** Prior authorization gold card pilots implemented by two Vermont payers in response to Act 140 were so narrowly crafted that no providers qualified; another program had low awareness and all programs exempted different types of procedures, medications or providers.^{vii} This fragmentation between payer programs can mean that it takes as much time and effort for a practitioner to determine if they are exempt from PA as to just go through the PA process. The Texas model of Gold Card programs for clinicians who have a 90% approval rate (as found in [H. 220](#) and [S. 151](#)) also have shortcomings – DFR notes that fewer clinicians have been exempt under the Texas law than expected.

It is time for meaningful action by every payer to reform prior authorization to an extent that the hours spent on administrative work are reduced and clinicians can spend more time in the exam room with patients.

ⁱ <https://www.healthvermont.gov/sites/default/files/document/HSI-stats-prov-phys20-detail.PDF>

ⁱⁱ <https://www.ama-assn.org/system/files/prior-authorization-survey.pdf>

ⁱⁱⁱ <https://www.ama-assn.org/system/files/prior-authorization-survey.pdf>

^{iv} <https://pubmed.ncbi.nlm.nih.gov/27595430/>

^v https://legislature.vermont.gov/assets/Legislative-Reports/DVHA_Act-140-of-2020_Prior-Authorizations-Report_Final-with-Appendices.pdf.

^{vi} <https://gmcboard.vermont.gov/sites/gmcb/files/documents/01-13-23-MVP-Health-Care-Act-140-2020-Gold-Carding-Pilot-Report.pdf>

^{vii}

[https://legislature.vermont.gov/Documents/2024/WorkGroups/House%20Health%20Care/Prior%20Authorizations/W~Julia%20Boles~Department%20of%20Financial%20Regulation%20\(DFR\)%20and%20Green%20Mountain%20Care%20Board%20\(GMCB\)%20Presentation%20-%20Act%20183%20\(2022\)%20Report%20-%20Prior%20Authorizations;%20Administrative%20Cost%20Reduction~4-26-2023.pdf](https://legislature.vermont.gov/Documents/2024/WorkGroups/House%20Health%20Care/Prior%20Authorizations/W~Julia%20Boles~Department%20of%20Financial%20Regulation%20(DFR)%20and%20Green%20Mountain%20Care%20Board%20(GMCB)%20Presentation%20-%20Act%20183%20(2022)%20Report%20-%20Prior%20Authorizations;%20Administrative%20Cost%20Reduction~4-26-2023.pdf) – see slide 13)