MEMORANDUM

BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association.
bluecrossvt.org

TO: House Health Care Committee

FROM: Sara Teachout, Corporate Director, Government, Public & Media Relations

DATE: February 26, 2024

RE: H.766 draft 2.2

The questions below pertain to H.766 draft 2.2 and the questions sent to Blue Cross VT:

Section 1 - Step Therapy and Drug Prior Authorization Questions

As noted in previous testimony, the proposed limits to the use of step therapy in a broad set of circumstances will significantly restrict a payer's ability to require members to try lower cost drug alternatives (limits described in the Blue Cross VT testimony page 10–11). With the new statutory limits added in Section 1, members who are currently using a high-cost drug when a less expensive alternative becomes available, must be allowed to stay on that drug in most instances. The interrelationship between the step therapy limitations in Section 1 and the prior authorization limitations that apply to medications in Section 4 (D) and (E) further proscribe the ability of a health plan to manage pharmaceutical costs.

Blue Cross VT has an exception process for individuals for whom the step therapy medication protocols are inappropriate. The process is outlined in a variety of consumer and provider facing materials, including certificates of coverage.

It is not possible to answer the questions pertaining to prescription drug prior authorization in specific instances because these data elements are not tracked. Blue Cross VT provides prescription drug denial rate data annually to DFR as part of the Act 152 Reports. Recent data indicates that in 2023, there were 15,254 drug prior approvals requested and 24.39% were denied; 5% of denied prior authorizations were appealed (for all reasons) and of those, 57% were approved on appeal.

Step therapy impacted 2,300 individual Blue Cross VT members where high-cost drugs have therapeutic equivalents (Blue Cross VT testimony page 4) which largely aligns with the figures citing the small percentage of members who account for the majority of total drug costs. Step therapy is only appropriate where there are therapeutic alternatives and therefore is not an option for the highest cost, first-in-class treatments.

Blue Cross VT requested several changes to the step therapy and prior authorization changes for medications including:

Sec. 1. 8 V.S.A. § 4089i(e) on page 2

(b)(iii) remove the clause "~~or other prescription drugs in the same pharmacologic class or with 9 the same mechanism of action~~" on lines 8 and 9

Add the highlighted language in the following section:
(b)(iv) the insured is stable on a prescription drug selected by the insured's treating health care professional for the medical condition under consideration and the "*patient would be at risk if moved to alternative treatment."*

Section 2 – Claims Edits Questions

In the new Sec. 2. 18 V.S.A. § 9418a (b)(1) all pharmacy claim edits would be eliminated until approved by DFR. This increases costs and leaves uncertain the future of routine pharmacy related edits that all national insurers use to help reduce excess utilization of expensive medication and reduce safety risks associated with contraindicated drug interactions or incorrectly drafted prescriptions. As Vermont's only local non-profit health plan, this will increase costs for Blue Cross VT members disproportionately because the law only applies to state regulated plans, the vast majority of which are served by Blue Cross VT.

Please add a new section to allow "*appropriate nationally recognized edit standards, guidelines, or conventions for pharmacy claims*" that are currently in place without a new requirement that these all require DFR approval. Blue Cross VT also requests a specific authorization for pharmacy claims edits: "*when edits are to protect the safety of the patient, prevent fraud, waste and abuse, or ensure that generics are used when consistent with 8 V.S.A. § 4605*."

The numbers presented for non-pharmacy claims in previous testimony are calculations provided by vendors and staff that reviewed which edits and claims corrections would be disallowed if these new provisions were to become law. There are hundreds of examples and the ones provided are not explicitly a NCCI edit or a MUE edit, thus they were included in the list, although they may be standard coding rules. Denying payment for units when provider bills more than daily allowable amount for the same member (excess billings of $1.7M); denying additional services already paid for through inpatient payment (excess billings of $1.1M in 2023); deny "add on" code when primary code was not billed (excess billings of $730,000.00); and claim lines that contain multiple, but mutually exclusive, diagnosis codes ($1M in excess billings).

The $6.4 million in higher payments specific to "prepayment coding validation edits" represent the total number of claims that were denied and not appealed, or upheld on appeal, in the first eleven months of 2023 as a result of prepayment validation. Vendor contracts are for multiple programs, vary by the phase of the work, and often contain value-based components. It is not possible to identify the payment specifically for prepayment coding validation.

Post payment audits are conducted in-house by Blue Cross VT staff. Audits are not specific to the use of claims modifiers for example – once a provider is identified for audit, the audit may be broad in scope. Auditing is a labor-intensive process for both the health plan and the

provider, often with prolonged timeline for resolution. Blue Cross VT has concluded these audits were not cost-effective when considering the resources to conduct the audits compared to the savings from corrective actions.

Section 3 Prior Authorization Questions

The team performed a high level review of the prior authorization (PA) proposal to align commercial prior authorizations with VT Medicaid (in the revised Section 3 version of H.766) using the VT Medicaid portal for CPT codes (over 44,576 lines of codes). This is incomplete and does not include HCPCs codes, diagnoses codes, dental codes, among other issues that are listed separately. Where there was not alignment, the review did not dig more deeply into the relationship between prior authorizations and benefits, nor did it look at the nuances of prior authorization within a specific benefit. A detailed review will take a dedicated project team to analyze the full scope of the proposed changes.

Further discussion with DVHA experts indicate that aligning prior authorization will be a significant project that will require resources and expertise from both DVHA and commercial payers to fully understand the differences between the programs and is further complicated because DVHA utilizes the coding system differently (for example Medicaid typically uses “H” codes for cost accounting while Blue Cross VT does not, among other variances.) Formal communication and collaboration would need to be established in order for commercial payers to access the information required to mirror the prior authorizations.

Prior approvals are not routinely denied due to payer administrative error, although it does happen. When a provider submits a prior approval request without sufficient documentation to respond to the request and does not supply additional information upon inquiry, that prior approval is denied after 45 days. Most prior approval requests that are submitted incorrectly are corrected and processed.

For the clinically denied prior authorizations the total cost of care depends on the facts of any specific case. It should be noted that payers have no advantage to driving up the cost of the care. When analyzing whether to require a prior approval, the cost of deferred necessary care is specifically considered as an important factor.

Blue Cross VT requests excluding prior authorizations relating to advanced imaging, genetic testing, durable medical equipment, enteral nutrition and outpatient surgery. Advanced imaging is frequently overutilized and is a high margin service for providers and the target of revenue enhancement strategies. Much genetic testing is clinically not yet proven and most is extremely expensive. DME is an industry prone to fraud and excess resource utilization. (A recent example is the urinary catheter fraud being investigated by Medicare.) Enteral nutrition is extremely costly and outpatient surgery has one of the highest denial rates for prior approval. Blue Cross VT has a nationwide network and the prior authorization policies contemplated in this bill will apply both to in-state and out-of-state providers.

Blue Cross VT supports reducing administrative burden by aligning payer requirements for prior approval as much as possible, but recognizing that Medicaid serves a different population and has significantly lower costs for equivalent services.

In addition to the list of exclusions in Section 3 page 11, and the requests above, please add "*prohibit prior authorization requirements for any high cost admission, item, service, treatment, or procedure*."

Blue Cross VT would support work to research Medicaid and commercial payer prior approval alignment, and phase-in the new policies, but the timeline proposed in the bill requiring health plans to "not impose any prior authorization requirement for any admission, item, service, treatment, or procedure that is more restrictive than VT Medicaid", combined with the new notification windows for providers to meet a January 1, 2025 implementation date will be an extraordinarily difficult timeline to meet. Considerations should also include having Medicaid align with commercial policies where appropriate.

Section 4 – Prior Authorizations

In 2023, Blue Cross VT received no requests for an extension of Epclusa. Currently, seven members are on this medication, which costs $70,000 for a 12 week trial. In the last 2 years, there have been 34 prior approval request s for Hepatitis C drugs, with 19 approvals and 15 denials. As noted above, treatment costs for patients with Hepatitis C would be specific to each individual. It is not uncommon for overutilization to be systematically supported by the distribution system for extremely profitable drugs.

The projected costs for the impact of the 90 day extension is between $500,000 to $1 million. In 2023, approximately one third of retail prescriptions were for 90 days.

In Section 4 (page 13) 8 V.S.A. § 9418b(g)(4)(D) Blue Cross VT suggests changing the word "*prescribed*" to "*prescription*" on line 18.

Blue Cross VT does not have recommendations for changes to the Reducing Administrative Burdens Working group in Section 6.