BlueCross BlueShield of Vermont
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April 4, 2024

Dear Chair Lyons and Members of the Senate Health and Welfare Committee,

Thank you for considering our serious concerns with many of the changes contained within H.766 pertaining to step therapy, claims edits, and prior authorization. Blue Cross VT appreciates the amount of administration that is required of the providers we all depend upon for our most important health care needs. We are working on improving the impact our organization has on provider requirements while balancing the need to protect our members and our fiscal responsibilities.

Some of the provisions are improvements we support, but other sections will have negative financial impacts, questionable benefits for providers, and may add – rather than reduce – complexity. Blue Cross VT estimates that collectively, these changes will increase premium costs by 5-7% next year, before any other cost growth. These are costs borne by your constituents.

Please consider the suggested modifications below to mitigate the financial impact to our members and customers. The negative consequences to Vermonters who rely on our health care plans are expected to be substantial from implementing these proposals.

Step Therapy Restrictions (Section 1)

Why we are concerned:

- Prescription drug costs for Blue Cross VT grew by 24.9% between 2022 and 2023.
- Step therapy asks fewer than 2,600 members per year with high-cost drugs to use equally effective, lower cost alternative medications when they are available.

What we support:

- We support many of the changes, including allowing members who transfer health plans within the same insurer to retain their medication and prior authorization protocols.

Please consider these amendments to contain drug costs without negatively impacting patient care:

1. Please remove the clause "*or other prescription drugs in the same pharmacologic class or with the same mechanism of action."* Section 1, page 2, (e)(1)(B)(iii)

Efficacy is patient-specific in many cases, so a different drug within the same pharmacological class may be effective for an individual when the first drug tried was not.

2. Please remove: *the insured is stable on a prescription drug selected by the insured's treating health care professional for the medical condition under consideration;* Section 1, page 2, (e)(1)(B)(iii)

   Many patients with chronic conditions will require their medications for years. This prevents a health plan from offering an alternative when it becomes available or better contract terms are negotiated. While many providers are knowledgeable about new prescriptions, it is difficult to keep abreast of all of the advances and developments and every alternative medication available. Lower prescription drugs costs help patients with their out-of-pocket costs and deductibles.

The prior authorization sections that apply to medications are also impactful for many similar reasons.

~~3.~~ Please strike the last clause requiring a prior authorization for longer than the ordered course of treatment and only renewed every five years.
Prior authorization approval for a prescribed treatment, service, or course of medication shall be valid for the duration of a prescribed or ordered course of treatment ~~or one year, whichever is longer provided, however, that for a prescribed or ordered treatment, service, or course of medication that continues for more than one year, a health plan shall not require renewal of the prior authorization approval more frequently than once every five years.~~ (Section 3, page 13 (D))

Claims Edit Modifications (Section 2)

Specifically this section contains changes to:
- limit claims edits to NCCI for outpatient and professional and MCE for facility claims:
- the process for updating or changing claims edits; and
- broadly prohibits prepayment code edit validation.

Why we are concerned:
- A large number of financial controls are eliminated by requiring only NCCI and MCE claims edits.
- Commercial health plans pay providers far more for the same services than Medicare and identifying in inappropriate coding has a far greater cost impact
- Blue Cross VT covers a number of outpatient, professional and facility claims that Medicare does not, leaving these claims without any appropriate claims edit review.
- Inappropriate coding costs commercial members directly in increased out of pocket costs – 40% of our members have high deductible health plans – and increases premiums for everyone – that isn't true of Medicare members.

- Limiting claims edits to only Medicare in Vermont puts us far out of line with other payers nationwide. Blue Cross VT is a local carrier, but we cover claims submitted from providers across the country – not just VT-based providers – and we need to be competitive, current, and protect our members from inappropriate claims on a scale that is much larger than our state.

Please consider these changes to the types of claims edits that can be applied:

1. Allow nationally recognized standards, guidelines or conventions for all types of claims

or:

1. Add to pharmacy claims in (C) – any claim type not covered by Medicare (don't exclude all outpatient, professional and facility claims); and

2. Do not restrict DFR in (D) from approving claims edits if they see fit for A, B, or C and please remove the underlined language in (D) "for any other claim not addressed by subdivision (A), (B), or (C) 12 of this subdivision (1)" and

3. "Grandfather" existing claims edits that have been in place prior to January 1, 2023.

Prior Authorization Changes (Sections 3 and 4)

Section 3 requires private health plans to adopt prior authorization standards "for any admission, item, service, treatment, or procedure" that aligns with Medicaid by January 1, 2025 – prescription drugs and some other important areas excluded.

Why we are concerned:

- This proposal could be extremely disruptive to patients.
- There are significant differences between private health plans and Medicaid that have not had thorough consideration including coverage, benefit and plan design, price differences for identical services, federal and state laws, among others.
- Requiring private health plans to match Medicaid prior authorization processes by January 1, 2025 is unreasonable and could result in implementation.
- It is unclear whether ceding all control for prior authorizations to Medicaid will improve patient care, control costs, or better serve the health care system.

Please consider a deliberative process, that includes payers and VT Medicaid working collaboratively to find alignment between prior authorization programs with appropriate time to change medical policies, train staff, update IT systems, and evaluate the consequences.

Section 4 requires quicker turnaround time for urgent prior authorization from 48 hours to 24 hours. (Section 4 beginning on page 12). Blue Cross VT is largely supportive of this change. Currently, no emergency care ever requires a prior authorization, and approximately 14% of the prior authorization requests we receive are considered "urgent." Additionally, we very much appreciate the effective date for this one particular section that allows us until January 1, 2026 for the changes that will require us to upgrade our technology. We are working with our new partners in Michigan to streamline our systems and it involves an essential IT upgrade.

1. There are two permanent exclusions we would like to request from the 24 hour turnaround time for **out-of-network care** and **durable medical equipment** The reasons are:

    - Out-of-network care involves negotiating the price for the care in addition to the prior authorization because these providers are not contracted with Blue Cross VT. We need to execute a single-case agreement for the medical service and this is difficult to accomplish within 24 hours.

    - Blue Cross VT only requires Durable Medical Equipment prior authorization for expensive equipment and the prior authorization is obtained by the DME supplier not the medical provider. This isn't reducing administration for a typical provider's office. DME is provided locally, but increasingly from national suppliers where we along with other payers are faced with more challenges and higher frequency of fraud, waste or abuse.

This is a complex piece of legislation dealing with many important aspects of the health insurance system. The details are critical. Please balance the benefit of administrative simplification against the extraordinarily high costs paid for health care by Vermonters.