Vermont Medical Society

HEALTH FIRST

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To: Green Mountain Care Board, submitted via gmcb.rate@vermont.gov
From: Vermont Medical Society, Jessa Barnard, Executive Director, jbarnard@vtmd.org
Health First, Susan Ridzon, Executive Director, sr@vermonthealthfirst.org
Re: Public Comment, Blue Cross and Blue Shield of Vermont and MVP Rate Filings

Both Blue Cross and Blue Shield of Vermont and MVP have submitted rate requests for the individual and small group markets that reflect an approximately .9% premium increase due to Act 111/H. 766, a bill that reforms step therapy and prior authorization. Despite requests throughout the legislative session and after reviewing what is publicly available in the rate review documents, the Vermont Medical Society (VMS) and HealthFirst (HF) have not access to the actuarial analyses by the payers nor seen a detailed section by section breakdown of how these costs are the result of Act 111. Responses referenced in the rate review documents are either largely redacted or confidential. VMS and HF ask the Green Mountain Care Board (GMCB) to closely review these details with a skeptical eye towards attributing additional cost to Act 111. Based on conversations through the legislative session, VMS and HF do not believe that payer estimates take into account existing data regarding the lack of premium impact of similar changes made in other states or by other payers, nor the full savings that could be attributed to reducing administrative costs and delayed care.

Step therapy and prior authorization add costs to the entire health care system:

- **Added health care costs because of prior authorization & step therapy:** for example, when a patient is sent to the ER to obtain imaging because requests from primary care providers (PCPs) are denied.

- **These costs are hurting patients:** A recent KFF study found that one-quarter of adults whose insurance problems included prior authorization problems said their health status declined as a direct result of problems they had with their health insurance, while one-third said access to needed care was delayed or denied, and more than one-third said it resulted in higher out-of-pocket costs.

- **Added administrative costs to the health care system:** costs of vendors, technology, and staff to process paperwork, staff turnover and burnout from prior authorization, step therapy and processing insurance claims. One estimate is that administrative costs of a PA ranges anywhere from $20 to $75 for payers and providers depending on the workflow.

See additional responses to assertions of the cost impact of Act 111 by section:

Section 1 - Step Therapy - Requiring patients to try and fail different medications before obtaining the medication recommended by their prescriber. **Act 111 does not eliminate step therapy:**

- Act 111 only allows clinicians and patients to request exceptions from step therapy in certain circumstances.
- Nearly identical language is already in effect in 22 other states, including Massachusetts and New York.
- A comparison by the ad hoc Safe Step Act Coalition of premium changes in the 37 states with step therapy laws, to the states without, demonstrates that the laws have no effect on premiums. (Link to chart)
- When asked in testimony to the House Health Care Committee this session, MVP could not state that the law already in effect in New York impacted their costs.

- Step therapy itself can increase health care costs: When step therapy leads to a patient failing to take their medication or having to take an ineffective medication for a prolonged period of time, this can lead to irreversible disease progression, lengthy hospital stays and other side effects. Payers previously did not appear to include any of these avoided costs in their estimates.
- This section also requires access to at least one appropriate asthma inhaler without PA. A recent study estimated excess direct medical costs (provider visits, ED visits, hospitalization) associated with uncontrolled versus controlled asthma are $1,349 per year. It does not appear that avoided costs are taken into account in payer estimates.

Sections 2 & 5: Claims Edits – Aligning billing standards with national standards.

- As reflected in updated filings/responses, Act H 890/Act 185 has delayed the implementation of claims edit alignment with federal standards until 2026.
- BCBSVT, the payer with a "prepayment coding validation edit" now prohibited by Act 111 as of 1/1/25 did not factor savings from their 2024 claims edit policy into 2024 rate filings, so it is unclear why ending the policy would now lead to increases in rates for 2025, as stated in their 6/27/24 memorandum. The estimates also do not appear to account for savings from reduced vendor costs specific to this claims edit policy.

Section 3 – Prior authorization – Reducing prior authorization for primary care providers.

- Real world evidence from Vermont's Medicaid program (see charts and discussion on pages 11-12) has shown that eliminating prior authorization for services like advanced imaging did not increase utilization or health care costs. There is no reason to think that the implications would be different for private payers. The fact that per unit cost is higher for private payers does not have an impact on incentives or reimbursement for an ordering primary care provider. In fact, a higher cost for private payers leads to a higher out of pocket cost for patients, potentially decreasing the incentives for ordering or receiving imaging.
- Peer reviewed data shows that eliminating PAs can reduce other health care spending: one study shows that eliminating PAs for buprenorphine reduced use of inpatient substance use disorder treatment and emergency department visits; another shows higher health care costs overall when patients were not able to obtain type 2 diabetes medications requiring PA. It is unclear that payers take into account savings from care received in a more timely way or in the appropriate settings.
- Kaiser data shows that nearly all appeals are overturned, suggesting waste and inappropriate decisions in the initial denial. Data showing overturn rates is also available on VT payers from DFR.
- Prior authorization leads to higher administrative costs for the entire health care system such as the need for contractors, staff to process paperwork, high staff turnover and burnout, and pulling clinicians away from patient care and forcing them to spend hours on the phone or computer. It is unclear that payers are taking into count any administrative savings to the payers or providers from reducing PA.
- Projected increases due to reduced PAs likely do not factor mitigating effects of other utilization management methods such as audits, fraud/waste investigations, and educational efforts. In fact, payers will have the most real-time data regarding the impact of reducing prior authorization under Act 111. They could take almost immediate action to reach out to specific ordering providers or organizations should they see data indicating that ordering imaging, tests or procedures is increasing, making mid year corrections to mitigate any increases in ordering. Provider organizations stand ready to work with payers on such efforts.

Thank you for taking these comments into consideration and please reach out with any questions to jbarnard@vtmd.org.