



# H.766 FAQ

Response to Claims of the High Cost of Reducing Insurance Hurdles

**Health insurers claim that H. 766 will increase health insurance costs.** While the providers and regulators have not had access to the actuarial analyses, from statements made throughout the legislative session we are confident that H. 766 will decrease administrative costs and burden for the entire health care system including patients, providers, and payers - and that payer claims do not take into account the full impact of administrative costs and delayed care.

## Insurance hurdles 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 PCPs are denied.
  - *“I have resorted to sending anyone who needs same-day imaging to the ER because I know that medically the care should not be delayed. I do not send them for a consult, or because I am unsure of the workup or medicine. I literally send them for a study I cannot order. By seeing a patient in my clinic, determining the need for advanced imaging, and then sending them to the ER, I know and accept that I have taken up unnecessary resources. I know that the patient will get another bill for emergency room services.”* - Katie Marvin, MD, Family Physician, Lamoille County
- **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.
  - *“I have an 11-year-old patient with such severe behavioral problems that he cannot safely be in school without his medication. He’s had a remarkable sustained response to medication, which allows him to attend school and learn. His mother changed insurance, and they won’t cover the medication until he has tried and failed two other medications.”* - Fay Homan, M.D, Family Physician, Wells River, VTii
- **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. [Another study](#) of 11 clinics found that the prior authorization process for procedures cost the clinics \$1,456.00 in a single month, but approval was granted in 99.6% of procedure requests.
  - *“Insurance companies will argue and show cherry-picked data that demonstrate cost savings and/or no harm. Their figures rarely if ever account for direct or indirect costs to patients, providers, the contribution to burnout, repeat visits when their alternative ‘recommended’ therapy does not work, or overcrowding and overuse of emergency access when this is the path of least resistance for urgent needed testing or urgent needed treatment.”* - Phillip Skidd, M.D., Neuro-ophthalmologist at UVMMC

## See additional responses to assertions of the cost impact of H.766:

**Section 1 - Step Therapy** - Requiring patients to try and fail different medications before obtaining the medication recommended by their prescriber. **H. 766 does not eliminate step therapy:**

- H. 766 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.
- Comparing 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 the House Health Care Committee, MVP could not state that the law 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 have not included 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.

**Sections 2 & 5: Claims Edits - Aligning billing standards with national standards. H. 766 will not significantly reduce claims edits from current practice:**

- **NCCI (or “Medicare”) edits cover comprehensive** in-patient and outpatient services, including pediatrics and OB, and also apply to Medicaid programs. There is no indication that relying on the edits used by Medicare and Medicaid will lead to more incorrect billing.
- Under H. 766 a payer can apply to have DFR approve claim edit standards. Payers have not stated any specific claims edits standards that they think DFR will deny and why.
- Providers also dispute a number of other allegedly prohibited claims edits as these are already incorporated into Medicare’s claim edits and would be allowed under H. 766.
- BCBSVT, the payer with a “prepayment coding validation edit” did not factor savings from their 1/1/14 claims edit policy into 2024 rate filings, so it is unclear why ending the 2024 policy would now lead to increases in rates for 2025. The estimates also do not appear to account for savings from no longer paying for vendor costs specific to this claims edit policy.

**Section 3 - Prior authorization - Reducing prior authorization for primary care providers. H. 766 already exempts huge swaths of services from PA reduction - pharmacy & out of network services.**

- [DVHA evidence](#) has shown that eliminating prior authorization for services like advanced imaging did not increase utilization or health care costs.
- 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 account 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 and fraud/waste investigations.

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<https://legislature.vermont.gov/Documents/2024/WorkGroups/House%20Health%20Care/Bills/H.766/Public%20Comments/H.766~Katie%20Marvin~Letter%20of%20Support~1-23-2024.pdf>

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<https://legislature.vermont.gov/Documents/2024/WorkGroups/Senate%20Health%20and%20Welfare/Bills/H.766/Witness%20Testimony/H.766~Fay%20Homan~Member%20of%20PCAG%20Testimony~4-11-2024.pdf>