

OPPOSED

Statement of Sunee Mickle

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Blue Cross and Blue Shield of Kansas

House Committee on Insurance

Regarding 2023 House Bill 2283

February 20, 2023

Chairman Sutton and Members of the House Insurance Committee:

Blue Cross Blue Shield of Kansas (BCBSKS) is a locally operated mutual insurance company with more than 1,600 Kansas-based employees. We serve approximately 930,000 Kansans in 103 Kansas counties. BCBSKS maintains offices in 11 communities around the state, with corporate headquarters in Topeka. We appreciate the opportunity to share our concerns regarding House Bill 2283.

Prior authorization is a decades-old process to ensure patient safety, consumer protection, and to assist providers in medical situations where providers have choices in the delivery of care. It is considered an important, safe, commonsense tool and is used by nearly every health plan in America – including commercial plans, Medicare, Medicaid, state employee health plans, and the federal employee health plan. Health care is expensive and gets more expensive every day. Not all procedures are necessarily covered by insurance policies. Prior authorization does not prohibit the provider from making any medical decision, it simply clarifies what is covered by the patient's insurance and what is not.

For the vast majority of provider services, health plans do NOT require prior authorization. It is reserved for a small number of *non-emergent* services – certain surgeries, transplants, non-emergency hospitalizations, rehabilitation, and high-cost or high-risk brand name pharmaceuticals. At BCBSKS, roughly 75 percent of provider inquiries requested last year were submitted *voluntarily* by hospitals and doctors (these are referred to as pre-certifications). These are NOT required prior authorizations. We devote company resources to provide pre-certifications as a courtesy to the provider to confirm in advance that the service meets coverage criteria.

Prior authorization is already a highly regulated process, based on URAC (Utilization Review Accreditation Commission) guidelines and definitions that are stipulated by the U.S. Department of Labor. All prior authorizations must be based on evidence-based standards developed by the medical community, and many function as red flags that alert providers and health plans to immediate danger for a patient. House Bill 2283 creates a conflicting set of standards, which will only result in additional complication and confusion for both patients and providers. There are multiple examples of how prior

authorization protects patients, payers and the general public. You've all seen the direct-to-consumer advertising for new brand-name diabetes drugs such as Ozempic, Rebelsus, or Trulicity. Many of these drugs cost more than \$1,000 per month. They are highly effective products for people with diabetes and covered by most insurance plans. These drugs are also effective for weight loss. Off-label prescribing is common, but in some cases it can be highly susceptible to abuse. Ozempic, for example, is a very expensive drug being prescribed for patients without diabetes who merely want a weight loss drug that is paid for by insurance. This misuse of the prescription pad caused a national shortage of the medication for diabetics who truly need it and created an explosion in the insured drug spend (the latter of which ultimately raises health care costs for everyone). In this example, prior authorization helps ensure both patient safety and medical necessity, so diabetics have access to life-saving medication.

Almost everything can be improved, including prior authorization procedures and practices. However, House Bill 2283 is not the solution. In fact, this bill would create more confusion than ever.

House Bill 2283 is cut and pasted from another state and is thus poorly matched with existing Kansas laws. Many of its provisions are already mandated on health insurers. Kansas law already allows the commissioner of insurance to adopt rules and regs for utilization review (KSA 40-22a04) and she has done so in KAR 40-4-41 governing time frames for initial responses and first level appeals. Further, prior authorization for emergency room services is already prohibited (see KSA 40-4601 - 40-4603). In short, the bill is unnecessary in some instances, duplicative in others, contrary to existing law in some instances, expansive of state power over private employers --- and none of this is coordinated or reconciled within the bill.

House Bill 2283 mandates that utilization review entities grant special privileges to specified providers. This qualifies as a mandate under KSA 40-2248, 2249 and 2249a, which requires that health insurance mandates be submitted with a cost benefit analysis and then be "test tracked" on the state employees' health care plan (SEHP) to determine cost impact on the state. None of this has been done as required by law.

Additionally, House Bill 2283 is extremely broad. It covers fully insured group plans, self-insured employers, individual policies, Medicaid, state employees (SEHP), workers comp insurers, and employer group pools. The bill also attempts to force out-of-state employers to abide by Kansas prior authorization rules if they "have an employee in the state." (Is that living here, working here, vacationing here?) Kansas health insurance mandates have traditionally only covered groups and individuals, while ERISA self-insured groups have been exempt. This bill moves a large number of employers and employees under the jurisdiction of Kansas health insurance laws and will likely invite both confusion and litigation under ERISA.

It's also worth noting that House Bill 2283 fails to define several key terms throughout the legislation. For example, the bill requires that a utilization review entity can only review for a chronic condition one time. What is a "chronic" condition? What if the condition changes for better or worse? What if the patient changes insurers? The bill uses the terms "emergency," "urgent," and "regular" prior authorization? What exactly is "regular"? Those are just some examples of this bill's problematic ambiguity.

Finally, the "gold card" provisions of the bill (Section 7(b)), require utilization review entities to exempt providers from certain requirements if they have had a high degree of approved claims (even out-of-network providers). The "gold card" exemption must continue if the provider submits proof of between five and 20 claims that were "approved or would have been approved." However, the

provider chooses the claims for calculating the 90 percent standard. The provider may have submitted hundreds of other denied claims during the evaluation period but chose not to include those in the 5-20 claim sample. Even if a health plan does find enough evidence from the skewed sample to rescind a gold card, House Bill 2283 automatically allows the gold card to continue for an additional 90 days. Gold carding should allow health plans to reward doctors that meet higher standards for safe, appropriate, and affordable care — in return, these gold standard doctors agree to be accountable on the backend for costs and quality. That's not what House Bill 2283 does. Rather, it prohibits provider accountability (except in very limited and specific instances) and disincentivizes value-based care.

BCBSKS supports efforts to make prior authorization more efficient, as long as it preserves the goal of promoting safe, timely, and affordable access to evidence-based care for patients. However, communication and collaboration are critical to improving the process and reducing unnecessary burdens. An entire division of our company is dedicated to provider relations, and we go to extensive lengths to maintain transparent, two-way lines of communication with everyone in our network. Despite multiple avenues for providers raise concerns -- and despite multiple requests last fall to meet with Kansas Hospital Association about this issue specifically -- we were disappointed that they chose not to share their specific concerns (or proposed solutions) prior to House Bill 2283's introduction.

Employers and insurers rarely hear from their employees and customers about prior authorization challenges. We hear about the constant and dramatic increases in health care costs and the corresponding premiums. House Bill 2283 is an extreme bill that fails to address this issue and will create more problems than it solves.

Thank you again for the opportunity to submit testimony on this consequential piece of legislation.