Sneed Law Firm, LLC

Memorandum

To: The Honorable Jene Vickrey, Chair
House Insurance Committee

From: William W. Sneed, Retained Counsel
America's Health Insurance Plans

Date: February 10, 2020

RE: H.B. 2459

Mr. Chairman, Members of the Committee: Thank you for the opportunity to be part of this hearing today and to provide testimony on H.B. 2459, legislation that amends the state's utilization review requirements. My name is Bill Sneed and I am here representing America's Health Insurance Plans (AHIP).[1]

AHIP members place a tremendous value on providing patients with access to high-quality and proven health care treatments for those suffering from behavioral health conditions, including mental

[1] AHIP is the national association whose members provide coverage for health care and related services. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities, and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access, and well-being for consumers. Our members are committed to providing consumers with affordable products that offer a broad range of robust provider networks of quality, cost-efficient providers.

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health and substance abuse disorders. We believe that individuals with mental health conditions and/or substance use disorders need access to evidence-based care coordination with a focus on both primary medical care and specialized treatments and services. Health insurance providers recognize the importance of these services in contributing to overall well-being and have demonstrated a commitment to implementing programs that ensure patients have affordable access to quality, evidence-based treatments and care.

We also believe that a key part of providing patient-driven and high-quality care is paying particular attention to the needs of patients suffering from behavioral health conditions. As part of this, the use of utilization review and prior authorization is a critical treatment utilization and patient safety effort. Indeed, studies continually show wide variations in medical practice that demonstrate the need for health plans to focus on ensuring that patients receive top quality care – the right care, at the right time, in the right setting. Medical management tools such as utilization review are not the draconian tactics that they are often portrayed to be. In reality, the use of medical management in health care provides tremendous safety, efficacy and cost benefits to patients, and health insurance providers have sought to develop tools to also help ensure that care is consistent with evidence-based practices. The value of these tools has been recognized in numerous federal and state government-sponsored programs like Medicare and KanCare. It is critically important to recognize the importance of these tools and activities, and not dismantle programs that have been effective in addressing longstanding challenges to safe and affordable evidence-based care.

We also agree that patients seeking care for behavioral health conditions including substance abuse disorder have unique needs that may require immediate intervention. However, the answers can be found in areas such as improving efficiency and communication in addition to changes in how care is provided. Some of the changes proposed in HB 2459 have the potential to harm access by increasing costs and removing the ability of health insurance providers to address fraud, waste and abuse. Patients suffering from substance abuse disorder and their families deserve to know that the treatments and settings available to their loved ones are proven effective and safe. Medical management and tools such as utilization review are critical parts of providing that security.

We appreciate the intent of this legislation and believe that we all have a role to play in improving access to care for behavioral health conditions. However, it is important to note evidence-based medical practices are not always adhered to. Under a utilization review program, health care professionals assess whether a treatment plan is medically necessary or appropriate for the patient. For good reason, utilization review is an accepted and integral component of today's American health care system.

In addition to our general concerns about unnecessarily risking patient safety by removing key protections, there are several areas of the legislation that pose specific concerns. Examples include:

- Section 1(a)(2)(A)(ii) requires patients receiving care for services described in H.B. 2459 to be provided coverage without the imposition of utilization review for the first 180 days of medically necessary outpatient treatment and services provided in-network. One widely

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recognized benefit of utilization review programs is their ability to establish medical necessity ensuring that patients receive optimal care based on well-established evidence of efficacy and safety, while providing benefits to the individual patient. Health insurers use nationally recognized care criteria, the input of a pharmacy and therapeutics committee composed of specialty clinicians for specific medical protocols, and consideration of the latest medical evidence based on the highest standards of care. If implemented H.B. 2459 could unintentionally allow for unnecessary, wasteful, and potentially fraudulent healthcare services being administered for nearly 6 months before any check if they are needed or meet the highest standards of care.

- Section 1(a)(2)(B) provides that the medical necessity of any treatment shall be determined only by the treating provider. AHIP members have concerns, however, that placing these decisions solely in the hands of the treating provider is misguided and fails to take into account key factors including the need for care coordination. We are also concerned that this section is written in a way that could be misconstrued to mean that any treatment, not just those intended to treat substance use disorder, suicidal ideation or patients actively suicidal, shall be determined for medical necessity solely at the discretion of the treating provider. We fear this could have serious and unintended consequences and should be clarified.
- Section 1(a)(2)(C) provides that for any inpatient treatment, if there is no in-network facility immediately available for a covered person, a health insurer shall provide all necessary

network exceptions to ensure that the patient is admitted to a treatment facility within 24 hours. It is unclear what the term "immediately available" means nor how it could be practically verified in a reasonable timeframe.

In summary, AHIP opposes H.B. 2459 as written because the legislation removes vital tools that health plans need to identify and address fraud, waste, and abuse. Additionally, there are possible drafting errors that could have far reaching consequences unintended by the sponsors. We ask that the Committee preserve the flexibility of private payers and public programs to use these tools to help ensure safe, effective and affordable care for patients.

Thank you for allowing me to appear before you today on behalf of America's Health Insurance Plans. I am available for questions at your convenience.

Respectfully submitted,

William W. Sneed

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