March 11, 2024

To: Chair Wiklund and Members of the Senate Health and Human Services Committee

RE: SF3532

Dear Chair Wiklund and Members of the Senate Health and Human Services Committee,

The Cigna Group is a global health services company dedicated to improving the health, well-being and peace of mind of those they serve. Cigna delivers choice, predictability, affordability, and access to quality care through integrated capabilities that advance whole person health.

We respectfully oppose SF3532 1st engrossment as it is currently drafted. While not an exhaustive list of our issues with the bill language, I would like to highlight two primary concerns: the definition for adverse determination and the prior authorization exemption. As both a health insurer and a utilization review organization, Cigna can bring a unique perspective to the conversation.

Section 4: Definition of Adverse Determination

The addition of clause (2), beginning on line 2.24, does not allow for a utilization review organization to redirect care, as it would be counted as a denial. Using the term "less invasive" is not inclusive of all options that a utilization review organization may provide. Less invasive is not definitive; does it equate to less expensive, less risk, less time delay for the patient? If the utilization review organization suggests a more intensive, and more medically appropriate procedure would this also count as an adverse determination?

For example, for young children with headaches, many providers start with a CT scan which is a less expensive test than an MRI. However, the evidence-based guidelines indicate that an MRI is the better option because of the quality of the image produced. The prior authorization would allow the provider to go directly to the MRI, helping the patient avoid potentially harmful delays in diagnosis and the co-pay associated with an additional test.

The definition of adverse determination needs to be refined as it is part of the automated process language in Section 6, clause (4), and the report required in Section 11.

Section 13: Prior authorization exemption process

The Department of Commerce must develop recommendations for a prior authorization exemption process. Exempting providers from prior authorization would have several serious negative impacts, most notably it would increase inappropriate care and costs while not positively impacting patient outcomes.

The exemption process is flawed policy that has not worked in practice, and is built on a flawed premise, which asks patients to accept that even the best providers will get their care wrong and remain completely unchecked.

The State of New Jersey produced a fiscal note on their prior authorization bill (AB1255) that has both prescriptions and services is scope, similar to SF3532. While the fiscal note determined an "indeterminant" impact, Legislative Services indicated that prior authorization saves the state $177 million annually.

The actuarial firm Milliman, the same firm that produced the study on public option for Minnesota, produced a study on the elimination of prior authorization in Massachusetts. While SF3532 doesn't explicitly eliminate prior authorization, any exemption process could effectively end prior

authorization. Milliman found that commercial premiums could increase by between roughly $600 and $1,500 per member annually and Medicaid capitation rates could increase by between $270 and $1,100 per beneficiary annually if prior authorization were eliminated. This would result in an additional $5.5 billion in premium costs annually for commercial plans, and close to $3.5 billion in costs for Medicaid when applied to current enrollment in Massachusetts.

This fiscal impact should be considered by this legislature.

Simply because a provider reaches an approval rate, does not mean they will continue to order appropriately in the absence of a utilization review program. In fact, this exemption process has been shown to be unsuccessful in encouraging long-term, positive behavior change. A study published in *The New England Journal of Medicine* found that when incentives were removed for physicians in U.K. primary care practices, there were immediate reductions in documented quality of care across 12 indicators. Conversely, there was little change in performance on the six quality measures for which incentives were maintained. In another real-world illustration, a state Medicaid program implemented an obstetric ultrasound utilization review program, which used evidence-based guidelines to determine whether care was appropriate. After the program had been underway, it was temporarily changed to "notification only". Utilization increased 27% during the five-month hiatus in utilization review.

This is to say that in the absence of utilization review, utilization of services increases with no correlation to better patient outcomes; simply more cost to the health care system.

Conclusion

Utilization review plays a critical role in helping patients receive high-quality, evidence-based care, and it keeps costs down for the entire health care system. Beyond significant fiscal impact, we must consider the health and safety impact this bill will have on Minnesotans. Their well-being should be considered 100% of the time.

Consider the patient with non-small cell lung cancer (NSCLC). A form of genomic testing called molecular profiling can confirm the presence of specific cancer tumor gene mutations that are best treated with more targeted therapies. These targeted therapies are less toxic and lead to longer survival. However, up to 30% of NSCLC patients don't get the most effective treatment because they didn't get molecular profiling. We found that without utilization management, 40% of doctors were skipping this testing. Once utilization management was introduced to require the testing, about 25% patients changed to the more effective treatment based on the results, and the adherence to testing was nearly 100%.

SF3532 would dramatically curtail those benefits for patients. We believe there are several ways to streamline utilization review that create a better experience for providers without sacrificing patient care.

Sincerely,

Margaret Reynolds
Senior Director, State Government Affairs
margaret.reynolds@cignahealthcare.com