2021 NCOIL Annual Meeting Health General Session

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About AHIP

AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and coverage more affordable and accessible for everyone.

Visit www.ahip.org to learn how working together, we are Guiding Greater Health.

Our Mission Statement

We are champions of care.

Health insurance providers, working together as one.

Making health care better and coverage more affordable for every American.

Listening. And guiding the conversation on care.

We are advancing mental and physical health.

Always improving how and where we help others.

Harnessing the power of our collective expertise.

Turning healthy insights into helpful innovations.

All for the greater good.

So everyone can thrive in good health.

Together.

That’s what care does.

AHIP

Guiding Greater Health

Prior Authorization

Patient Protections & Provider Improvements

Prior Authorization – Protects Patients

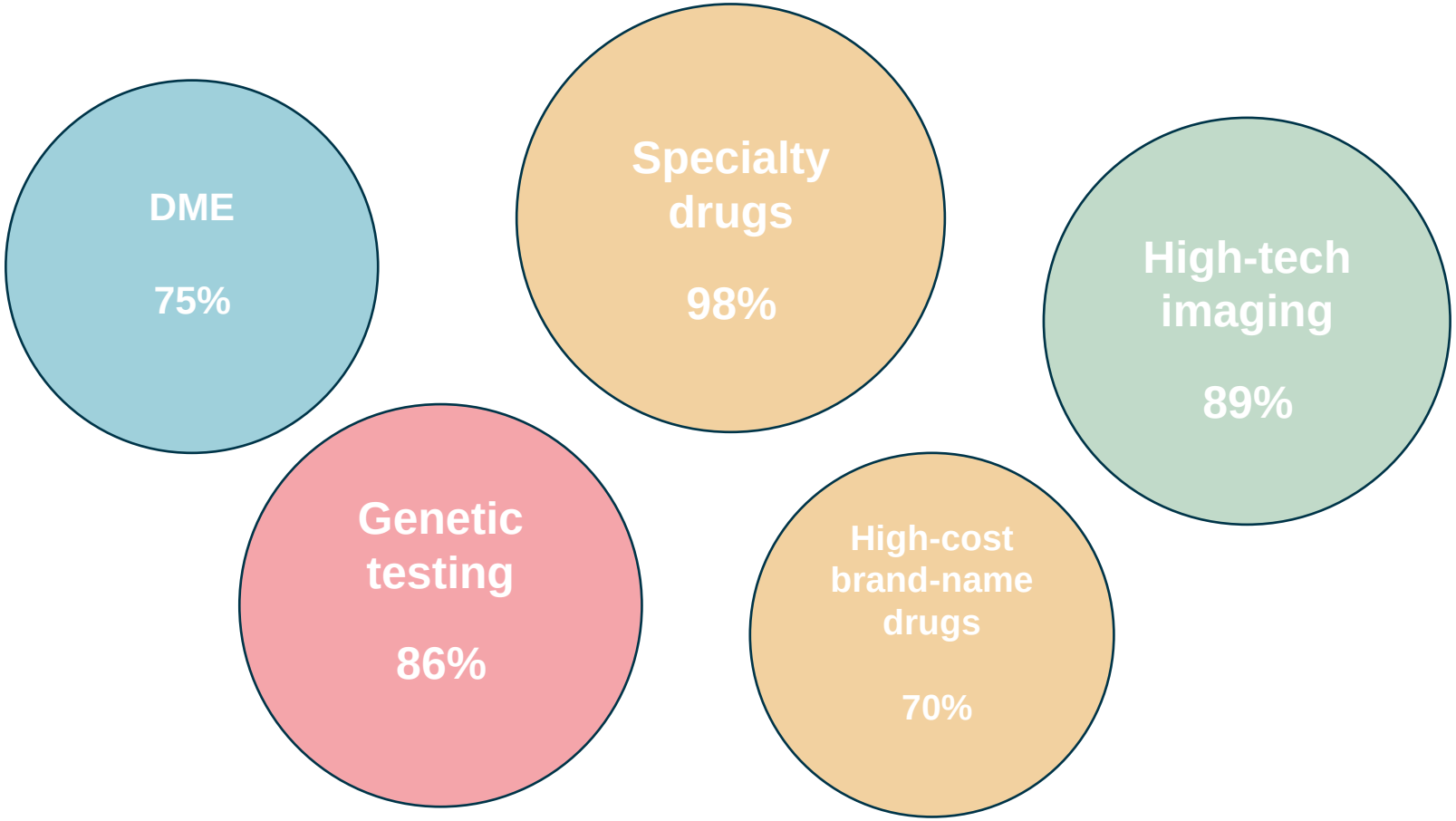
- **Prior Authorization provides patients financial protection.**
  - PA helps a patient understand if the service their provider is seeking is a covered benefit/covered service.
  - Providers want to take this away, either by drastically restricting it or outright eliminating it (i.e. via gold carding).
  - If providers succeed, policymakers need to understand that they are leaving patients to understand the benefit on their own and patients may be exposed to a new kind of “surprise billing” (not out of network surprise bill but rather a “not covered service” surprise bill).

- **Prior Authorization provides patient care protection.**
  - PA identifies overuse, misuse and safety issues for the patient BEFORE a provider delivers the care.
  - PA improves quality and care, holding providers accountable to providing care that is consistent with and supported by medical evidence.
  - PA triggers additional coordination of care services for the patient.

Prior Authorization – The Value is Well Documented

- Americans in each of your districts continue to receive unnecessary, low quality, and inappropriate care at a significant cost. Today, a wide variations in care occurs with little to no correlation between spending and quality.
  - ***Unnecessary Care**:*
    - 65% of physicians reported that at least 15-30% of medical care is unnecessary. (PLOS One)
    - One study estimates that the cost of waste in the U.S. health care system ranged from $760-$935 billion, accounting for approximately 25% of total health care spending. (JAMA)
  - ***Low quality/value care:***
    - Many original Medicare beneficiaries receive "low value" care – where there is little or no clinical benefit or where risk outweighs potential benefit, at an estimated cost of $2.4-$6.5 billion a year. (MedPAC)
    - Just 5 low-value services account for more than $25 billion in unnecessary spending. (Task Force on Low-Value Care)
  - ***Inappropriate Care:***
    - Nearly half of hospitalized children and teens were given at least one drug combination that could have led to adverse outcomes – e.g., opioids, antibiotics, and other infection-fighting drugs. (Pediatrics)
    - Up to half of all antibiotic use is inappropriate, exposing patients to additional risks. (JAMA)
    - The majority of patients were overprescribed opioids following elective procedures and there is wide variation in prescribing. (Annals of Surgery)
    - 30-60% of diagnostic imaging for three common conditions in one state was inappropriate. (Int. Journal for Quality in Health Care)

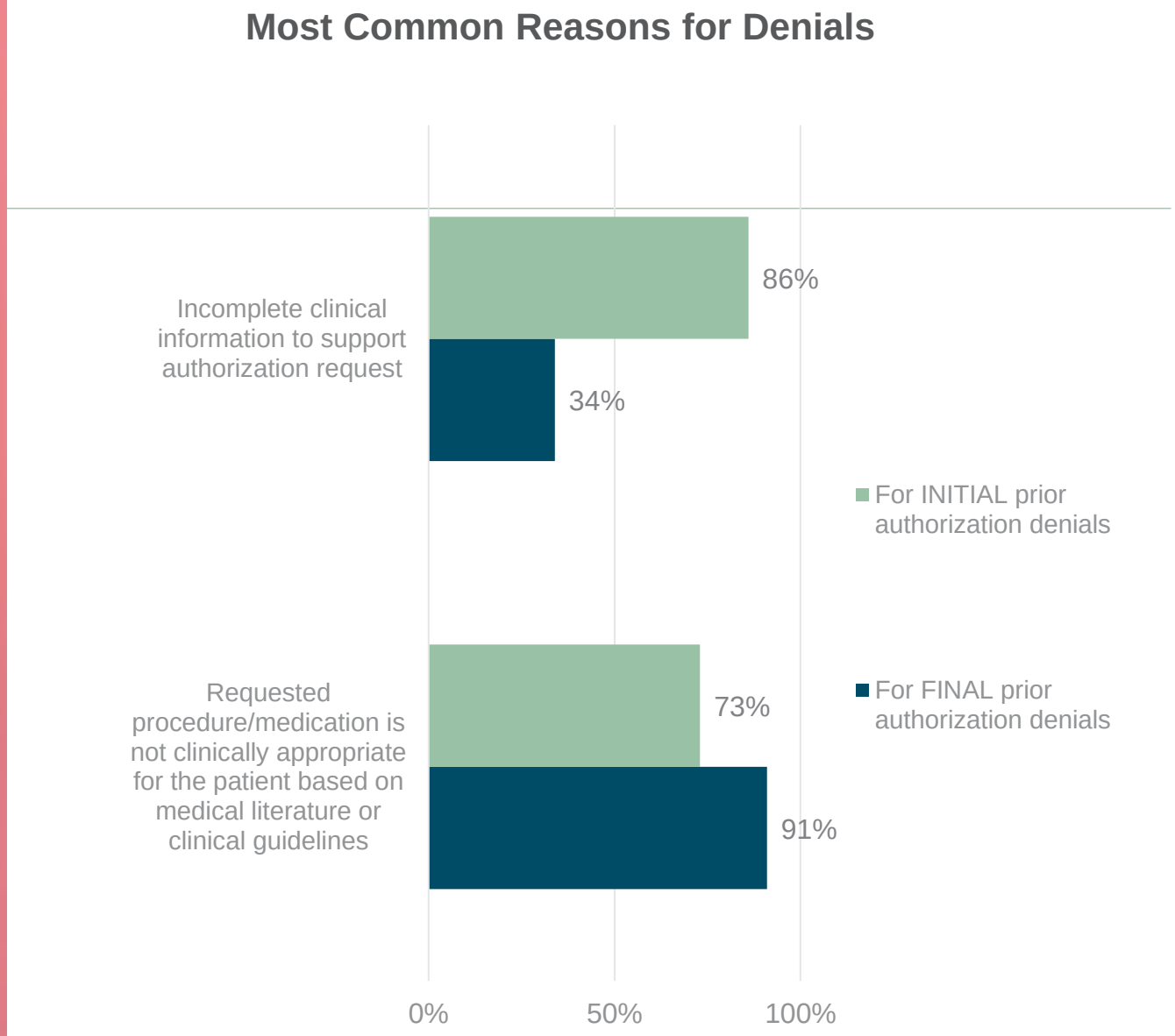
Most Common Treatments Subject to Prior Authorization



Primary care services: 0%

Incomplete information from providers is the most common reason for an initial denial.

Requested medical service or medication not being evidence-based is the most common reason for a final denial.



Prior Authorization - Gold Carding

- **Gold Carding Programs that <u>Preserve</u> Patient Protections**. Providers:
  - Meet the highest (gold/A+) standards for safe, appropriate, and affordable care.
  - Agree to be accountable on the backend for costs and quality.
  - Accept and manage more risk.
  - Receive an exemption from some or all of the requirements of routine prior authorization by increasing their own responsibility to conduct utilization management for a service they order for a patient. It requires these providers to consider whether the available criteria and evidence supports the service they are requesting for the patient.
  - Agree to regular reviews because of confidence in history and A+ status.

- **Gold Carding Programs that <u>Jeopardize</u> Patient Protections.** Providers:
  - Meet A- or B+ status.
  - Are not accountable for costs and quality and can shift that financial responsibility to patients, employers and taxpayers.
  - Sidestep regular reviews because they are relying on B+ record

Mandatory Gold Carding:
A Blank Check for Providers, Harmful for Patients

- Mandatory gold carding would create a blank check for certain providers — a guarantee of payment, even if the care is not otherwise covered by the health plan because it is not a covered service, is inappropriate or not medically necessary.
- Legislation that mandate gold carding or significantly reduce/eliminate prior authorization are dangerous for patients.
- Eliminating prior authorizations would remove checks on fraud, waste, and abuse.
- These bills would undermine practices that prevent harm, lower costs, and ensure care is delivered at the right place and time.

Improvements: Automation and Alignment

Opportunities to Improve Provider Burden and Improve Patient Care

Providers and Health Insurance Providers Working Together

- Providers and Plans agreed to work together in January 2018
  - The American Hospital Association (AHA), AHIP, American Medical Association (AMA), American Pharmacists Association (APhA), Blue Cross Blue Shield Association (BCBSA) and Medical Group Management Association (MGMA) announced a Consensus Statement outlining their shared commitment to industry-wide improvements to prior authorization processes and patient-centered care.
  - Agreement was to encourage the use of programs that selectively apply PA based on provider performance:
    - ***Reduce the number of health care professionals subject to prior authorization requirements*** based on their performance, adherence to evidence-based medical practices, or participation in a value-based agreement with the health insurance provider.
    - ***Regularly review the services and medications*** that require prior authorization and eliminate requirements for therapies that no longer warrant them.
    - ***Improve channels of communications*** between health insurance providers, health care professionals, and patients to minimize care delays and ensure transparency of information, rationale, and changes.
    - ***Protect continuity of care for patients*** who are on an ongoing, active treatment or a stable treatment regimen when there are changes in coverage, health insurance providers or prior authorization requirements.
    - ***Accelerate industry adoption*** of national electronic standards for prior authorization and improve transparency of formulary information and coverage restrictions at the point-of-care.

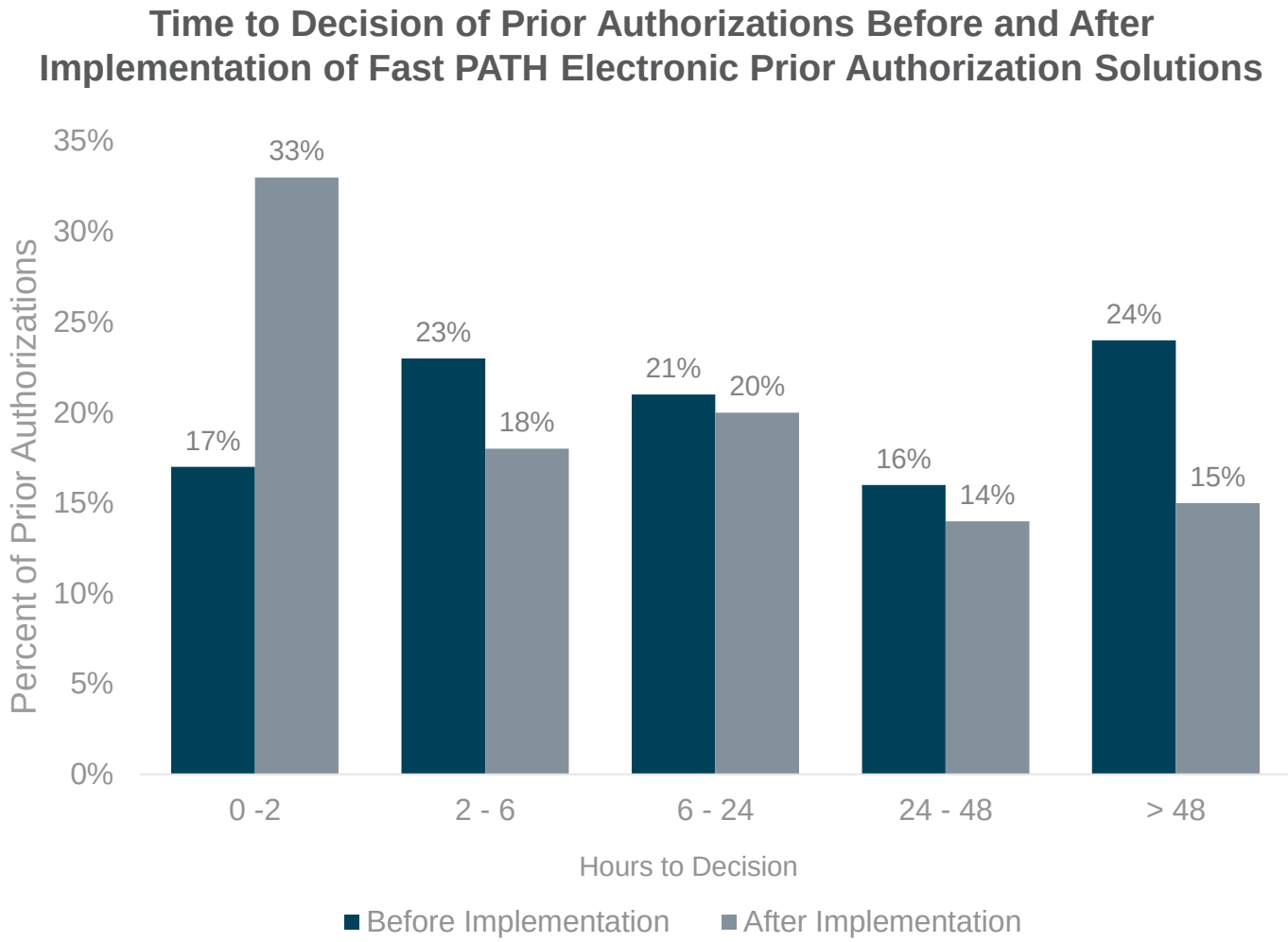
AHIP FastPATH Pilot

- Electronic Prior Authorization was identified as Key Opportunity to improve the process
- FastPATH – Results Announced in March 2021
  - Independent evaluation
  - Over 400,000 PA transactions
  - Survey of over 300 providers/staff
  - ***Key Findings:***
    - ***Decisions are made Faster***
    - ***Patients Received Faster Care***
    - ***Provider burden is reduced and providers can maximize the efficiencies of electronic prior authorization***

Faster Time to Decision

Significant benefit: **Reduced time** from the request for prior authorization to the decision.

- Median time between submitting a prior authorization request and receiving a decision was more than **3 times faster** with electronic process than manual – 5.7 hours rather than 18.7 hours – a reduction of 69%.



Faster Time to Patient Care

Providers reported that **patients received care faster** after providers implemented electronic prior authorization.

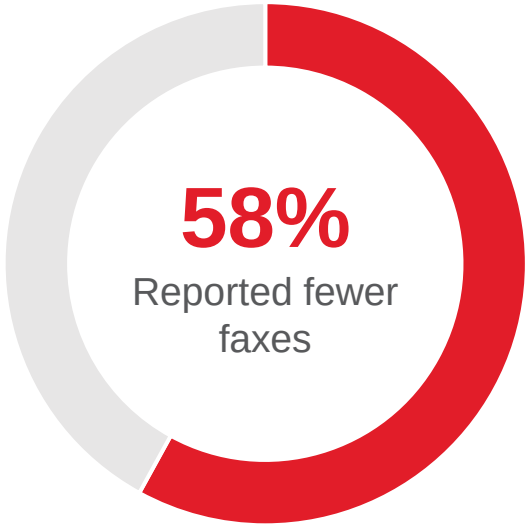
- Among providers using these solutions for most of their patients (referred to as “experienced users”), 71% reported that timeliness to care was faster after implementation of electronic prior authorization.

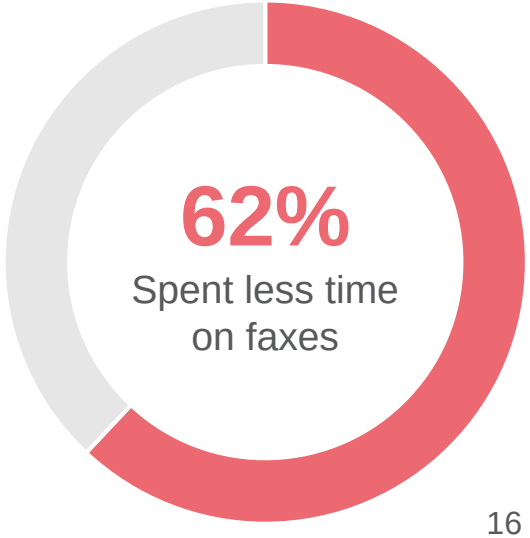
*Experienced users represent 31% of respondents who provided information about their level of experience.

Lower Provider Burden From Phone Calls and Faxes

Among experienced users…

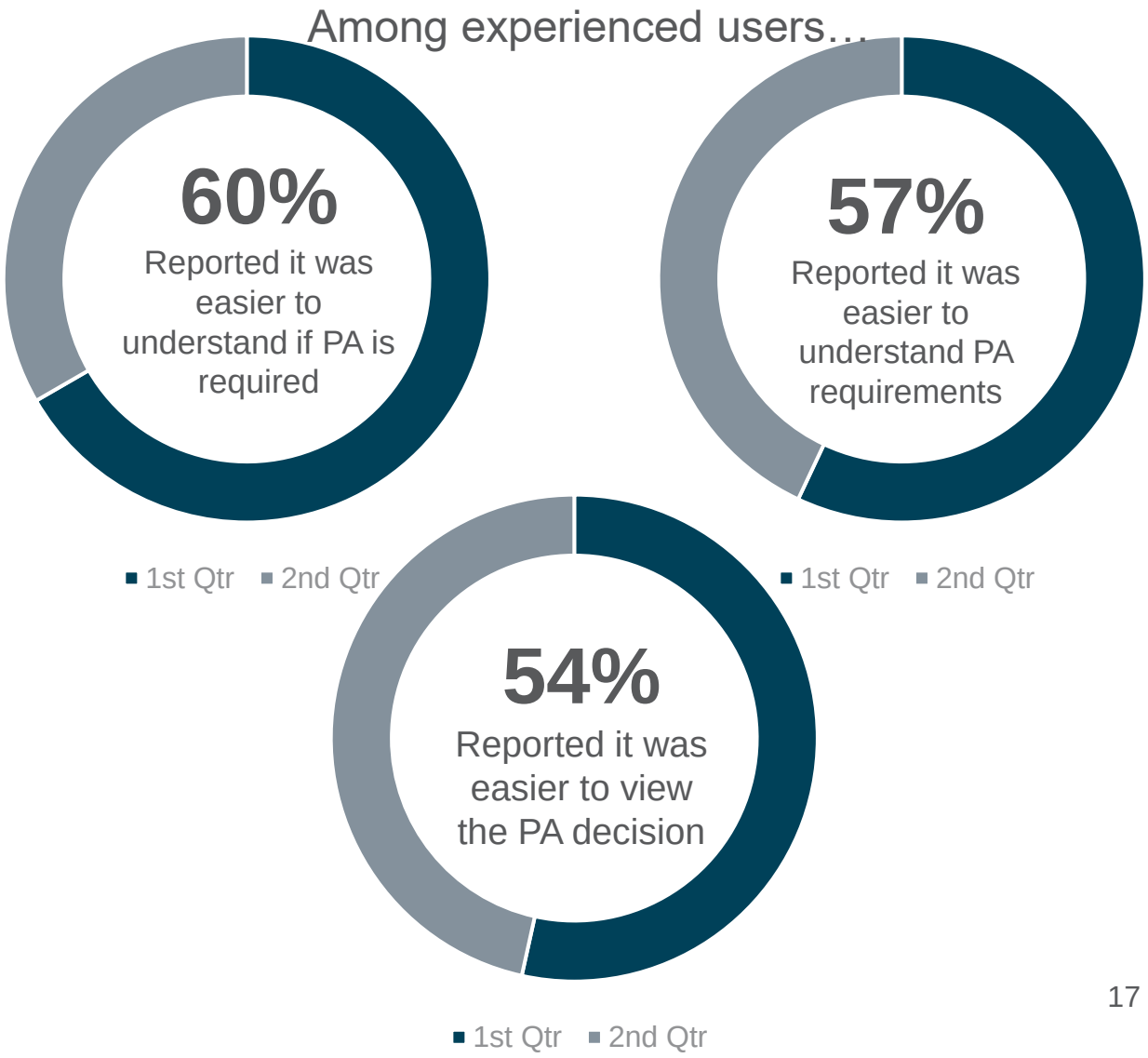
Among experienced users, a majority experienced **less burden related to phone calls and faxes** after implementation of electronic prior authorization.





Improved Information for Providers

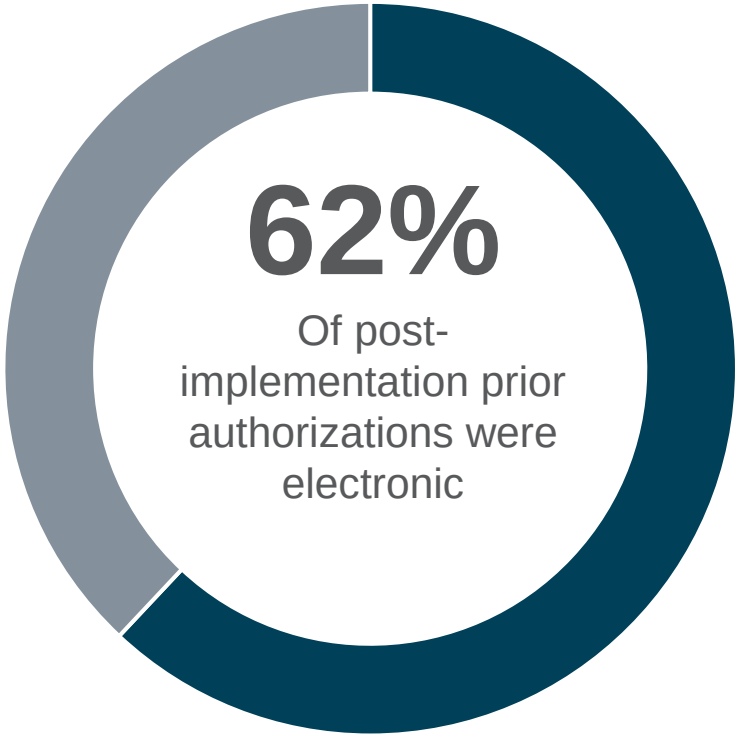
Among experienced users, most reported that it was easier to understand prior authorization information after implementation of the electronic solution.



Majority of Transactions Electronic after Implementation

Greatest Benefits for Experienced Users: The more frequently a provider used the technology solution, the bigger the benefit the provider experienced in reduced burden and ease of understanding prior authorization information.

While the majority of experienced users reported lower burden and greater ease of understanding prior authorization information, burden and ease of understanding was not as significantly impacted when the results included providers who used the technology for only a few of their patients.

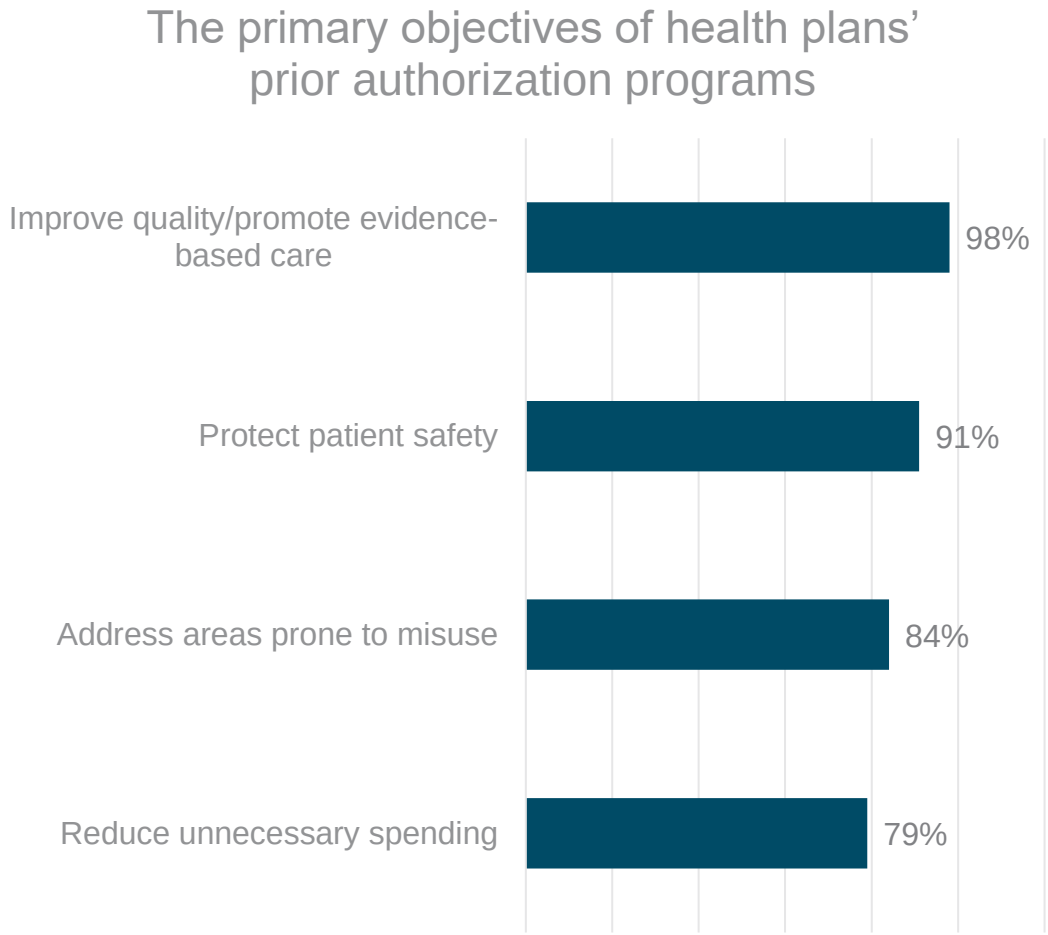


48%
fewer manual prior authorizations after implementation compared to before

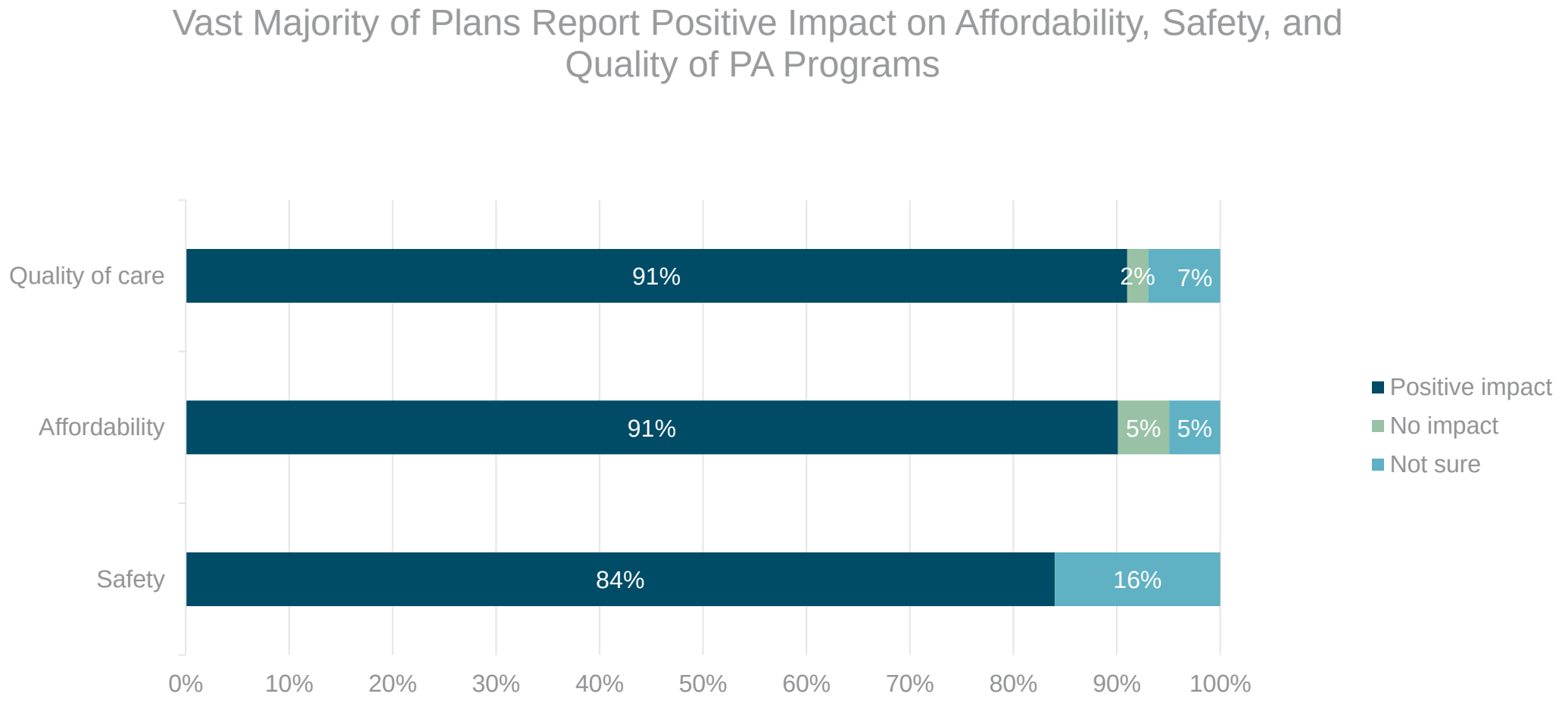
Appendix

Primary Goals of Plans' PA Programs

Quality, safety, appropriateness, and affordability are top goals of health insurance providers' prior authorization programs.

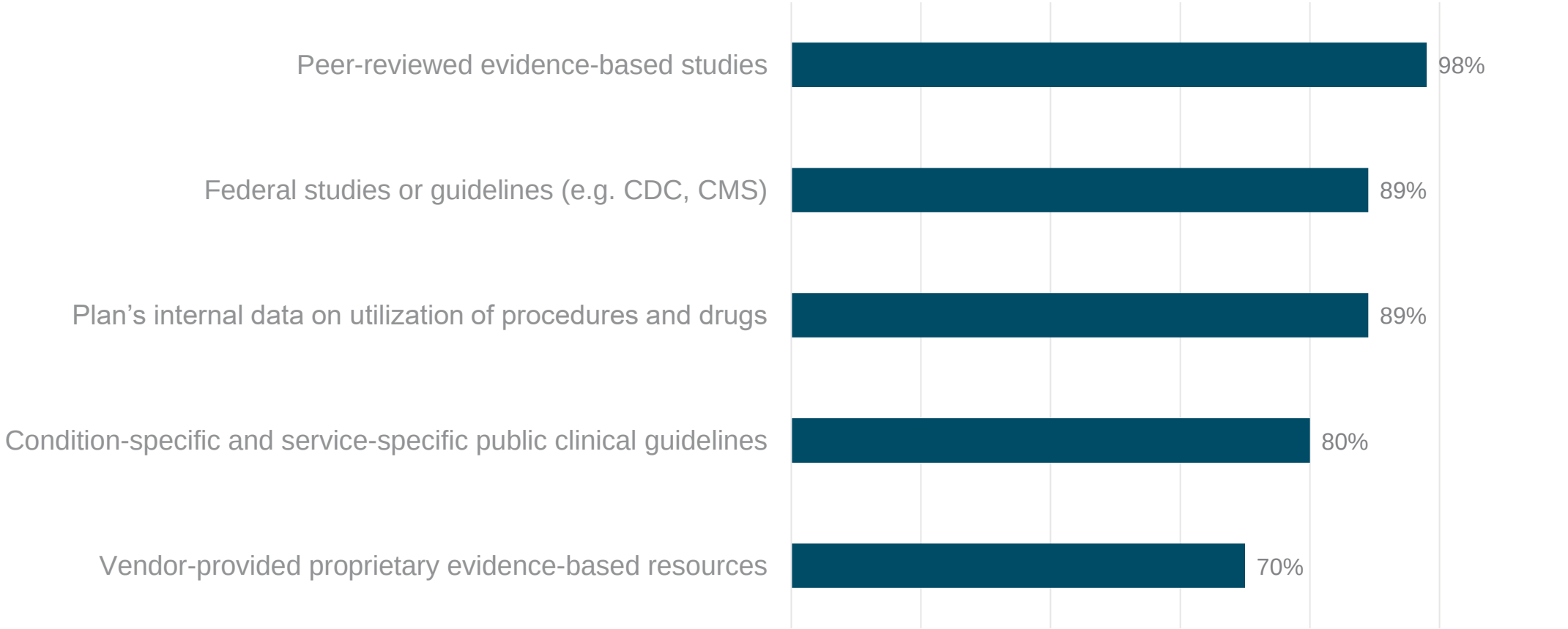


Positive Impact of Prior Authorization Programs



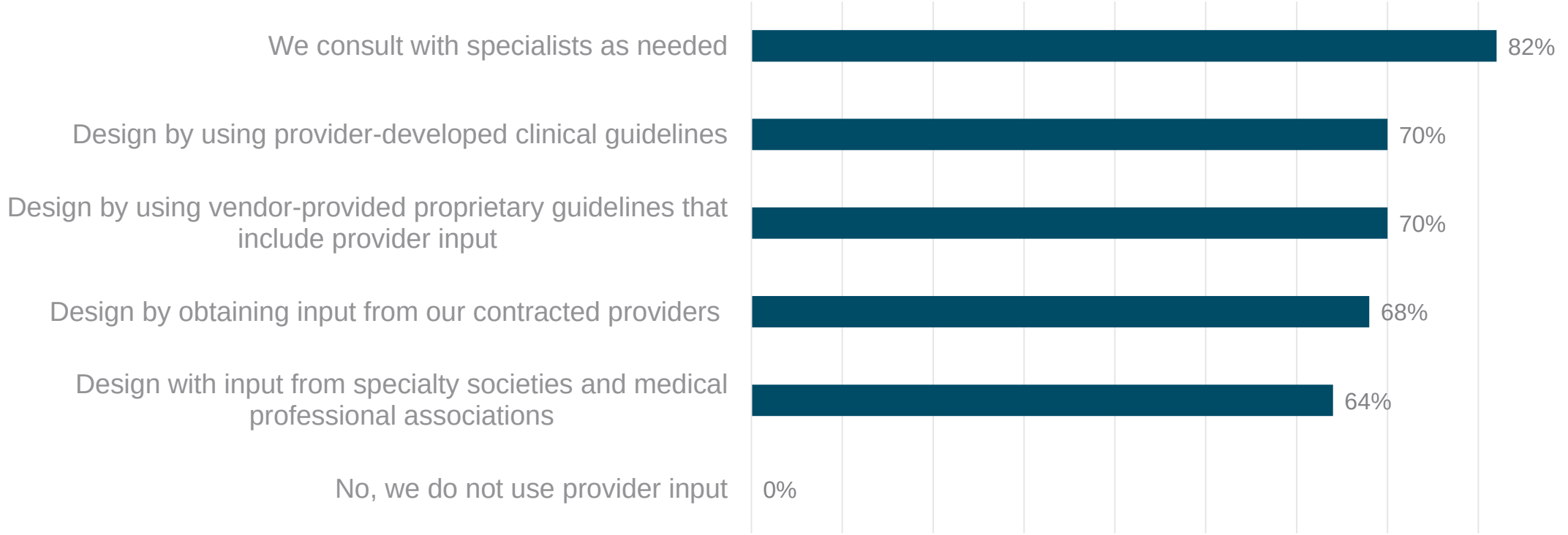
Prior Authorization Programs Are Evidence-Based

When asked what resources are used in designing their prior authorization programs, plans reported using a range of evidence-based resources

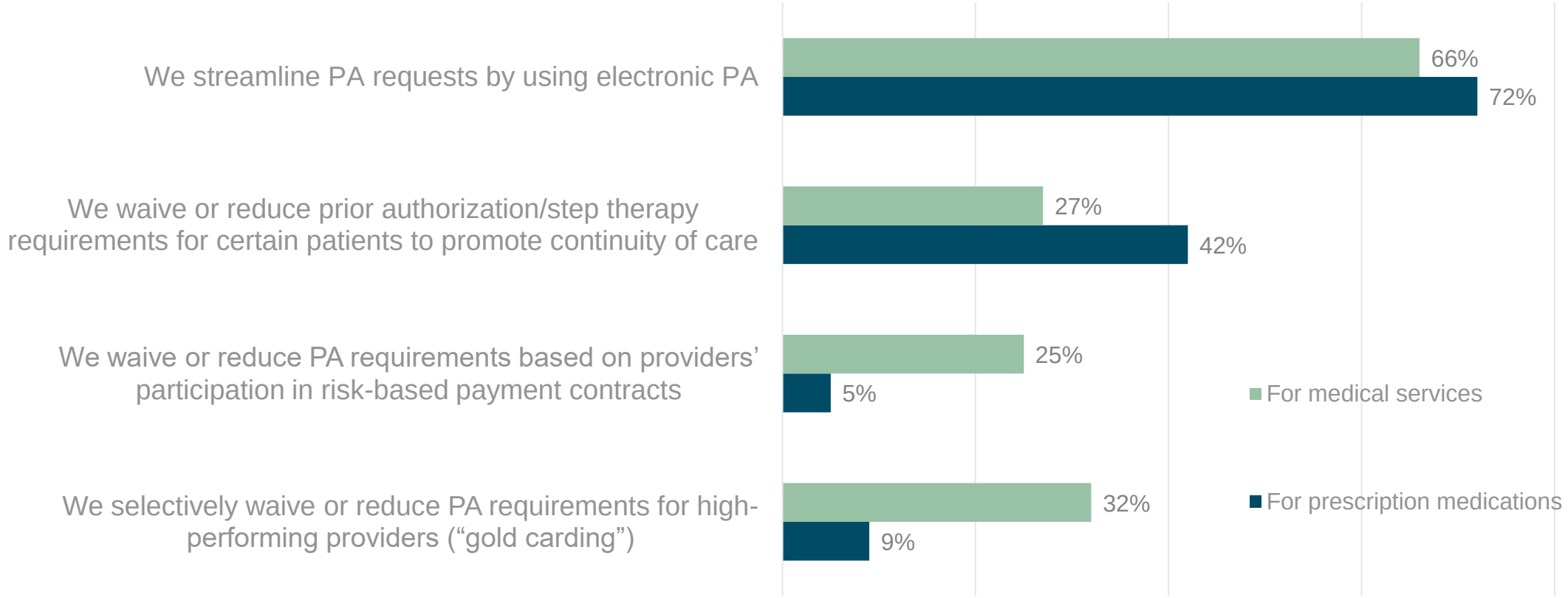


Prior Authorization Programs Use Provider Input

Does your plan get input from providers or provider organizations when you develop the list for drugs and procedures that are subject to prior authorization?

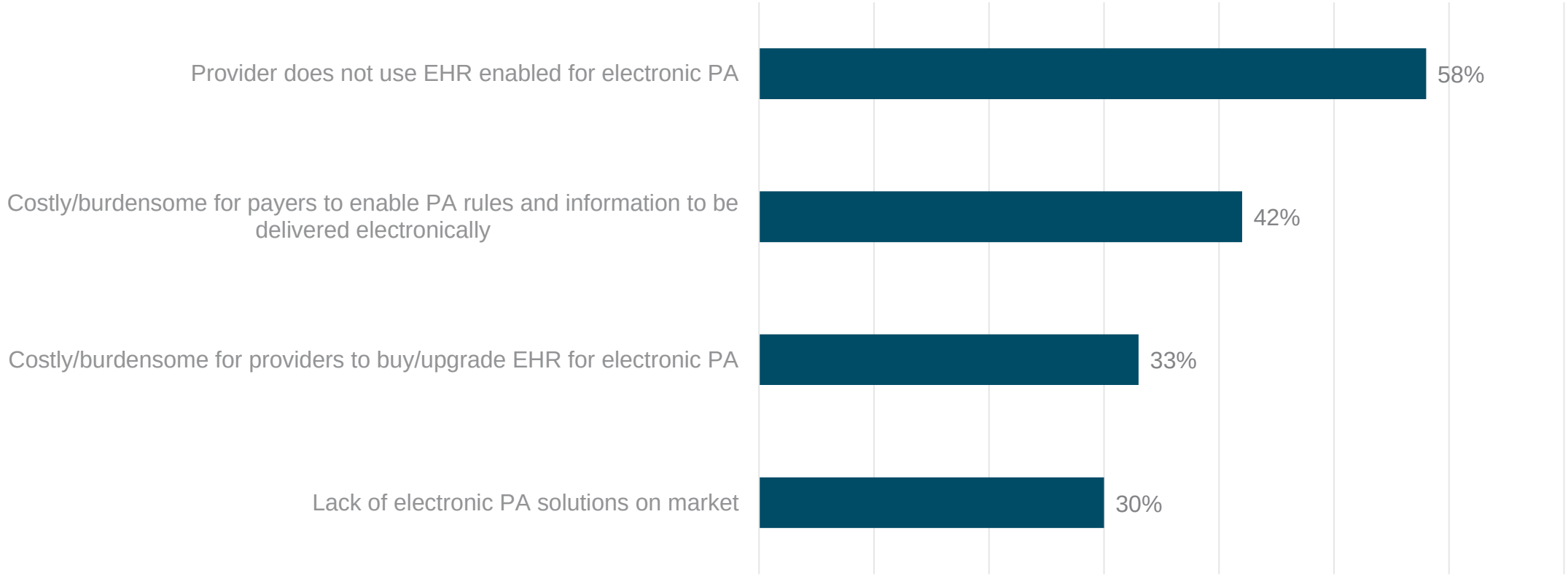


Majority of Plans Streamlining PA Through Automation



Barriers to Prior Authorization Automation

Providers not using EHRs enabled for electronic prior authorization is the main barrier to greater use of ePA



Thank You

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