NCOIL 2024 Annual Meeting

Prior Authorization: Promoting Evidence-Based Care That Is Safe & Affordable for Patients

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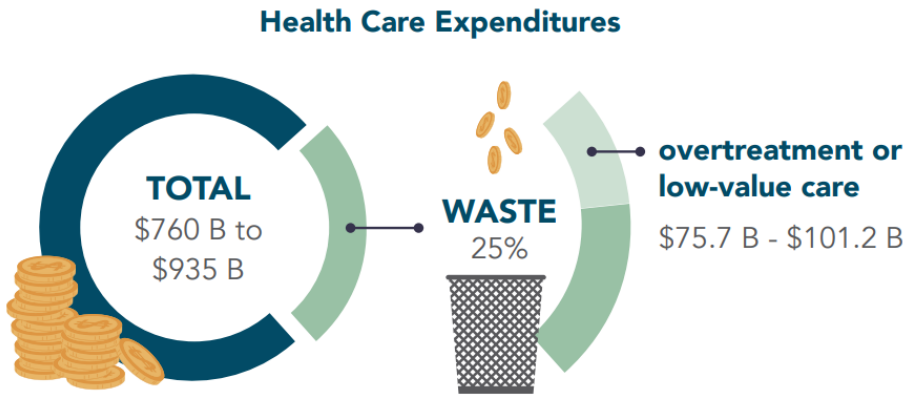
Why do health plans use prior authorization?



The Cost of Low Value Care

A 2019 JAMA study estimated that 25% of all health care expenditures ($760 billion to $935 billion) is due to waste in the U.S. health care system. Of this total, the portion due to overtreatment or low-value care was estimated to be $75.7 billion to $101.2 billion.

Case Study: Hyaluronic Acid Injections for Knee Osteoarthritis

Despite evidence that hyaluronic acid injection offers no meaningful difference in the lives of patients over placebo shots, injections are still widely given to treat knee pain caused by osteoarthritis.

Moreover, there is evidence that these injections result in a greater risk of negative side effects, including gastrointestinal inflammation and infections, cardiovascular problems, and blurred vision and dizziness. Prior authorization can help ensure that hyaluronic acid injections are not used as a first line treatment, consistent with providers' own recommendations.

Patients receive an average of 3.6 injections at an average cost of $310 per injection, for an average of **$1,128 per patient**.

Cost to Medicare of over $300 million each year.

https://ahiporg-production.s3.amazonaws.com/documents/202311_AHIP_Prior_Authorization.pdf

Consensus Statement on Improving the Prior Authorization Process

Our organizations represent health care providers (physicians, pharmacists, medical groups, and hospitals) and health plans. We have partnered to identify opportunities to improve the prior authorization process, with the goals of promoting safe, timely, and affordable access to evidence-based care for patients; enhancing efficiency; and reducing administrative burdens. The prior authorization process can be burdensome for all involved—health care providers, health plans, and patients. Yet, there is wide variation in medical practice and adherence to evidence-based treatment. Communication and collaboration can improve stakeholder understanding of the functions and challenges associated with prior authorization and lead to opportunities to improve the process, promote quality and affordable health care, and reduce unnecessary burdens.

The following five areas offer opportunities for improvement in prior authorization programs and processes that, once implemented, can achieve meaningful reform.

1. **Selective Application of Prior Authorization.** Differentiating the application of prior authorization based on provider performance on quality measures and adherence to evidence-based medicine or other contractual agreements (i.e., risk-sharing arrangements) can be helpful in targeting prior authorization requirements where they are needed most and reducing the administrative burden on health care providers. Criteria for selective application of prior authorization requirements may include, for example, ordering/prescribing patterns that align with evidence-based guidelines and historically high prior authorization approval rates.

   We agree to:

   - ***Encourage the use of programs that selectively implement prior authorization requirements based on stratification of health care providers' performance and adherence to evidence-based medicine***
   - ***Encourage (1) the development of criteria to select and maintain health care providers in these selective prior authorization programs with the input of contracted health care providers and/or provider organizations; and (2) making these criteria transparent and easily accessible to contracted providers***

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2018 Consensus Statement

Stakeholders signing the consensus statement committed to work together to improve the prior authorization process.

Goals of the commitment:

- Promote safe, timely, and affordable access to evidence-based care
- Enhance efficiency
- Reduce administrative burdens

Recognized the prior authorization process can be burdensome for all involved but there is wide variation in medical practice and adherence to evidence-based treatment.

5 areas of opportunities for improvement to achieve meaningful reform:

- Selective application
- Program review and volume adjustment
- Transparency and communication
- Continuity of patient care
- ***Automation to improve transparency and efficiency***

IMPROVING PRIOR AUTHORIZATION PROCESSES:

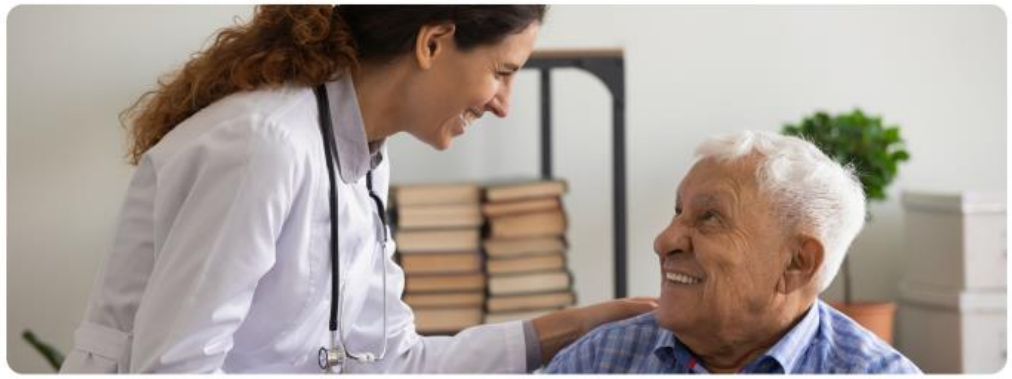
How Health Insurance Providers Are Delivering on Their Commitments

Every American deserves access to affordable, high-quality coverage and care. But too many of our nation's health care dollars are wasted through unnecessary, inappropriate, or even harmful care. Even doctors agree: 65% of physicians have said that at least 15-30% of medical care is unnecessary. This is unacceptable, particularly when combined with the fact that too many Americans struggle to access health care that is affordable.

Prior authorization (PA) is essential to support patient access to clinically appropriate, evidence-based care. Prior authorization can reduce inappropriate care for patients by catching unsafe or low-value care or care that is not consistent with the latest clinical evidence before it occurs – all of which contribute to unnecessary costs and potential harm to patients. Public and private purchasers of health care recognize the value of this essential tool.

While PA is critical in reducing unsafe, low-value, or inappropriate care, the process can be burdensome to providers, patients, and health insurance providers alike, especially when working on an outdated, manual, paper-based system. In 2018, stakeholders representing providers, insurers, and pharmacists developed a Consensus Statement recommending opportunities to improve the PA process.

Increasing the adoption of electronic prior authorization (ePA) was one of the major opportunities identified for improving the PA process. Using health information technology to exchange data has been demonstrated to improve health outcomes, enhance efficiencies, and reduce costs. Despite this opportunity, physicians, however, are lagging in their adoption of electronic health data exchange, including ePA. According to a recent study published by the Office of the National Coordinator for Health Information Technology (ONC), about one-third (35%) of office-based physicians still used only fax, mail or e-fax to share patient health information with providers outside of their organization in 2019. In addition, physicians' engagement in electronically sending, receiving, and integrating information did not change between 2015 and 2019.



AHIP
Guiding Greater Health

JULY 2022

How health plans are improving the prior authorization process

AHIP's most recent plan survey found that our members made progress in the 5 areas identified as needed improvement in the Consensus Statement signed by 6 national health care stakeholder organizations.

Over 90% of plans are streamlining the PA process through:

- Electronic prior authorization
- Waiving or reducing prior authorization for certain patients to promote continuity of care
- Waiving or reducing PA requirements based on providers' participation in risk-based payment contracts
- Selectively waiving or reducing PA requirements for high-performing providers

Elevance Case Study

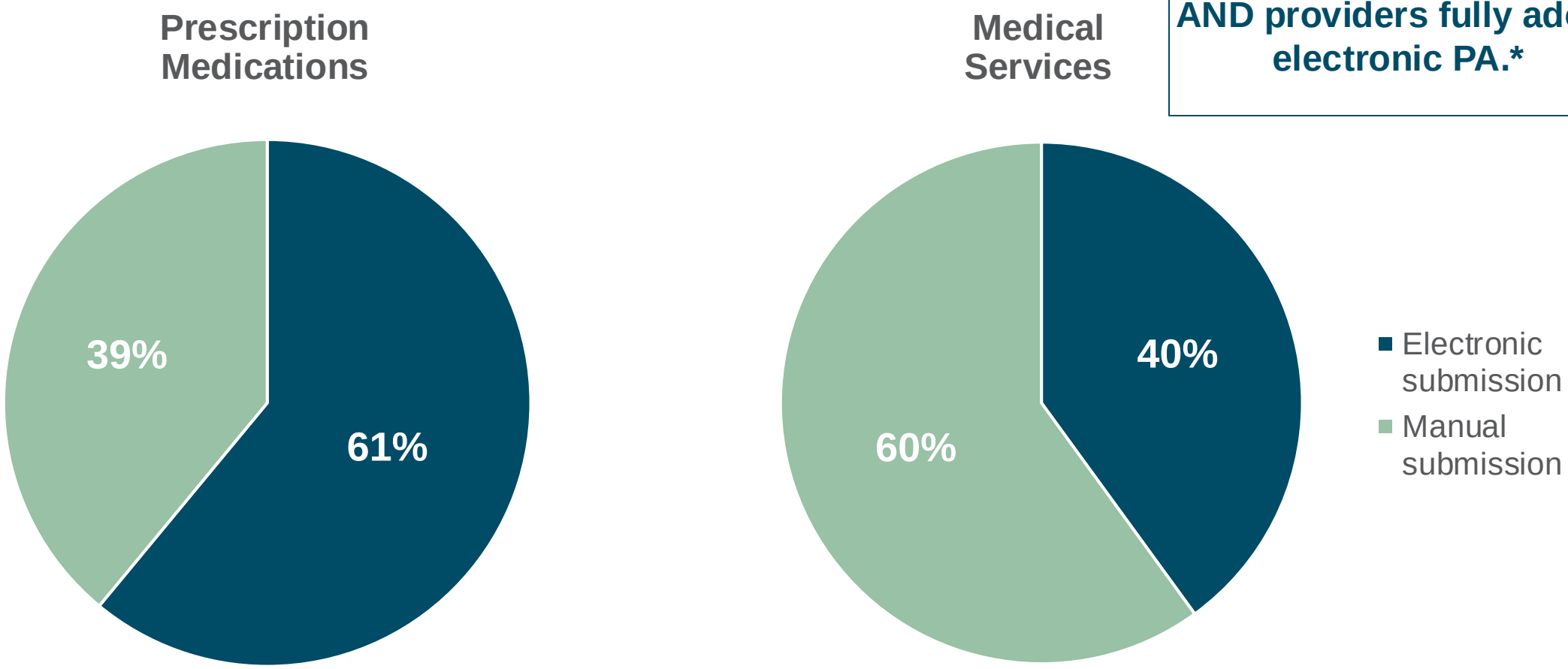
After implementing programs to streamline their PA process:

approximately 70% of PA requests are approved instantly

approximately 95% are approved in less than 24 hours

Major Barriers to Progress:
Large percentages of PA requests submitted manually

$449 million could be saved every year if plans AND providers fully adopt electronic PA.*



* CAQH

State Activity: 2-Way Electronic Prior Authorization

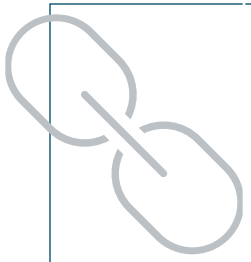
- D.C.
- Indiana
- Maryland
- Michigan
- Mississippi
- New Jersey*
- Oklahoma
- Pennsylvania
- Washington*
- West Virginia

CMS Prior Authorization API Requirements

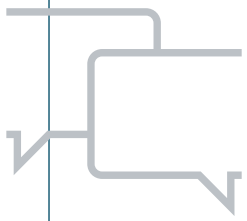
By January 1, 2027, impacted payers will be required to build an application program interface (API) to support ePA. The API must:

Be populated with the payer's list of covered items and services (excluding drugs) that require prior authorization

Identify all documentation required for approval of any items or services that require prior authorization



Support a HIPAA-compliant prior authorization request and response



Communicate approval, denial, or a request for more information

Safety and Affordability Risks for Patients

- **Clinical Appropriateness Measures Collaborative Project Key Findings:** About 10% of physicians provided care inconsistent with evidence-based standards of care, as defined by their respective specialty societies.
- **Milliman studied the potential impacts related to eliminating prior authorization requirements**
  - Without adequate utilization management, the cost of care could drastically increase.
    - A recent study conducted by Milliman showed that eliminating prior authorization could **increase premiums by $20.18 to $29.52 PMPM**
    - They estimated that eliminating prior authorization could lead to a total increase of **$43 to 63 billion annually** in the commercial market nationwide.
  - Prior authorization has an important Sentinel Effect on providers (where one's performance tends to improve when they know they are being monitored.
    - When the loss of the Sentinel Effect is factored in, Milliman predicts that the premium impacts will jump to **$51.19 to $130.28 PMPM**.
    - Health insurance providers have reported increased utilization when gold carding programs are put into place.

Thank You

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