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NCOIL Prior Authorization Model Legislation

Health Insurance & Long Term Care Issues Committee

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Overview

- Prior Authorization Overview
- Highlights of Current Bill
- Recommended Improvements
  - Post-Acute Care
  - Reviewer Credentials
  - Electronic Standard
- Wrap-up/Questions

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Prior Authorization: Overview and Need for Reform

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Prior Authorization: Delays and Disruptions in Care

- **Patient Experience:** 16% of all insured adults report an problem accessing needed care as a result of prior authorization. (KFF Survey, 2023)

- **Impact on care and health outcomes** (AMA Survey, 2024):
  - 93% of physicians report delays in care
  - 82% report patient abandonment
  - 29% report serious adverse event

- **Denials of Appropriate Care**
  - 13% denials were medically necessary (2022 HHS-OIG Report)
  - 75% of appealed authorizations overturned (2018 HHS-OIG Report)

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Differences in insurer requirements and submission methods

- **Is prior authorization required for a particular service?**
  - Specific treatments requiring authorization differs between health plans (even those issued by the same insurer).
  - Prior authorization list (and frequent updates) are often posted on a website or included in a monthly bulletin
- **What information/documentation required for approval?**
  - Prior authorization forms and clinical criteria used to evaluate requests varies
- **How should the request and supporting documentation be sent to the payer?**
  - Fax
  - Phone call
  - Portal
  - 278 transaction

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NCOIL Model Legislation: Highlights

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NCOIL Model Prior Authorization Bill

- **Disclosure and Validity of Prior Authorization Requirements**
  - Complete list of all services for which PA is required
  - Transparency of medical necessity criteria
  - Evidence-based, nationally recognized, patient-flexible criteria.
  - 60-day notice of new requirements
- **Time-restrictions**
  - 7 days standard requests, 48 hours urgent requests
- **Denial Specifics:** Detailed explanation and appeal information
- **Revocation Restrictions**
- **Continuity of Care**
- **Enforcement**

NCOIL Model Legislation: Recommended Changes

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Model Prior Authorization Bill: Recommended Changes

- **Electronic Standard:** Recommend mirroring federal requirements (plans and providers will already be using the HL7 standard)
- **Post-acute Care:** Classify all post-acute prior authorizations as urgent
- **Reviewer Credentials:** Recommend applying to all denials, not just appeals
- **Reporting Requirements:** Aggregate data instead of service-specific data
- **Insurer Review of Requirements:** recommend stronger language (periodically review and consider removal)
- **Length of Approvals:** Recommend 1 year rather than 6 months

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Post-Acute Care Prior Authorization

- **Post-acute Care:**
  - Long-term Acute Care Hospitals
  - Inpatient Rehabilitation facilities.
  - Skilled Nursing Facilities
  - Home Health
- **Issues:**
  - Higher rate of inappropriate denials (U.S. Senate Report)
  - More pronounced delays in care due to inability to schedule and receive approval in advance
- **Recommendations:**
  1. Validate and ensure proper use of medical necessity criteria
  2. Categorize all post-acute care authorizations as “urgent”

Reviewer Credentials

- **Denials of care:**
  - Significant disruption in patient care plan
  - Should consider individual patient needs
- **Issue:** Current model language only requires trained medical professionals to review denials when they are formally appealed.
    - Substantially increased delay in care
    - Potential for treatment abandonment or less-effective treatment
- **Recommendations:** Require all denials or other adverse coverage decisions to be reviewed by a physician with expertise in the field of medicine or health care at issue before being issued

Electronic Standards

- **No current industry-standard method of submitting prior authorizations to plans**
  - Phone
  - Fax
  - Portal/Website
  - ASC X12 278
- **Issue:** Although current model legislation requires plans to establish and use proprietary websites/portals.
  - Requires clinician to use different log-in and different processes for each plan
  - Requires EHR data to be extracted and uploaded to plan platform
  - Inconsistent with CMS requirement and recent insurer pledge to use FHIR
- **Recommendations:** Require plans to utilize the CMS-mandated and emerging industry-standards for prior authorizations (FHIR API/NCPDP SCRIPT)

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Key Take-Aways

- Prior Authorization is ripe for reform
- Required revisions are consistent with other plan requirements
- Updated model bill will substantially improve patient care and administrative burden and costs

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Contact / Questions

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