

Prior Authorization.

David Rosenbloom, PhD
Professor Emeritus



Boston University School of Public Health

bu.edu/sph | [@BUSPH](https://twitter.com/BUSPH)

Thanks



Outline for tonight

- Confession and history
- Definition
- Context for Hawaii
- Case for and against Prior Authorization
- Concession: its not going away
- Reforms by carriers, feds, other States
- Suggestions
- Questions and Comments

My Confession: In the room where it happened



"Well, it's the Renaissance and I'm a man, ergo I'm a Renaissance man. But, yes, I mainly sell cheese."



- The Health Data Institute
- Huge variations in frequency and cost
- Insurance companies: show employers we are doing something to limit cost
- Desk top computing
- Prior certification; second opinions ;large case management;

Original design was negotiate but defer to treating MD

*in the late 1980s, the “main strategy” of “high-cost case management” was to **“discuss and negotiate appropriate care rather than to refuse prior authorization** of benefits explicitly,” with denial rates estimated to fall between one to two percent*

COMMITTEE ON UTILIZATION MANAGEMENT BY THIRD PARTIES, INST. OF MED.,
Controlling Costs and Changing
Patient Care?: The Role of Utilization Management 43 (Bradford H. Gray & Marilyn J. Field eds.,
1989).

Prior Authorization is

- [Healthcare.gov](https://www.healthcare.gov) defines prior authorization as “approval from a health plan that may be required before you get a service or fill a prescription in order for the service or prescription to be covered by your plan”.

Hawaii Context for PA in the healthcare ecosystem

Severe MD, provider shortage

Insurance carrier monopoly

High use of prior authorization

Very low PA appeal rates

Significant variation in population health and
needs by location

Healthcare ecosystem matters for population health

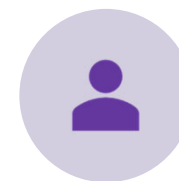
- Financially stable public and private payers
- Employer and patient costs low enough to be affordable—no medical bankruptcy



PAYMENT AND WORKING
CONDITIONS GOOD
ENOUGH TO ATTRACT AND
KEEP ENOUGH PROVIDERS



HOSPITAL PAYMENT HIGH
ENOUGH TO MAINTAIN
PLANT, EQUIPMENT AND
PERSONNEL



PATIENT ACCESS AND
CONFIDENCE

Insurers want PA.



PREVENT SOME UNNECESSARY
OR HARMFUL CARE



MAY BE CHEAPER WAY TO
ACHIEVE SAME RESULT



REDUCES CURRENT SPENDING
ON CORE MEDICAL CARE

Prior Authorization is key element in insurers' business model

Rebates (extra payments) to Medicare Advantage plans doubled between 2018 and 2023



Reduces Current spending on core medical care



Frees cash for profits or extra benefits; low premiums, dental



Reduces provider productivity/billing



Enables low bidding on next medicare advantage premium; generates rebates for extra benefits for enrollees and profits

No PA in traditional Medicare but lower cost to feds than Medicare Advantage

- 6% more for MA than traditional Medicare
- projected \$27 billion in 2023.
- MedPac Report to Congress; Medicare Payment Policy, March 2023

Prior Authorization Doesn't work

Little evidence of efficacy; research equivocal

Does not save health system money

No consistency among carriers

Contributes to provider burnout

Harms patients

AI making it worse

Research: no strong evidence

IMPACTS OF PRIOR AUTHORIZATION ON HEALTH CARE COSTS AND QUALITY

A REVIEW OF THE EVIDENCE

Ani Turner, George Miller, Samantha Clark
November 2019

2 Evidence of Impacts on Health Care Use and Spending

There are a modest number of studies on the impacts of PA programs on health care utilization and spending. Prescription drug applications have been received the most study. Some research has also examined use of PA for imaging, medical devices, transportation, and other therapies.

The research shows that PA programs reduce utilization of the targeted treatment, sometimes with offsetting increased use of preferred treatments. The evidence also shows PA programs generally reduce spending on the targeted care, although where overall health care costs are tracked, the PA-focused reductions do not always translate to lower overall health spending.

While the evidence base is not substantial enough to draw firm conclusions, PA effectiveness has varied by the type of care to which it has been applied. Brief summaries of selected research findings on the impacts of PA on health care use, cost, and quality for various types of care follow.

Medical imaging. There is evidence that PA for medical imaging can be effective in reducing utilization and associated health care costs. Multiple studies have found PA policies were associated with reduced use of magnetic resonance imaging, computer-aided tomography scanning, and cardiac imaging.¹⁰

6

PA costs a lot of money

The Hamilton Project • Brookings
 1MARCH 2020 Reducing Administrative
 Costs in U.S. Health Care

David M. Cutler Harvard University

BOX FIGURE 1.

Estimates of Administrative Expenses



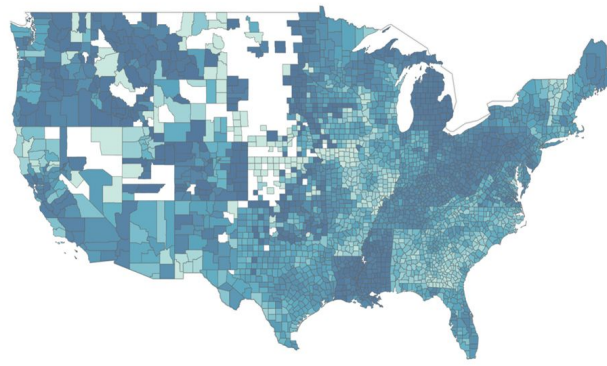
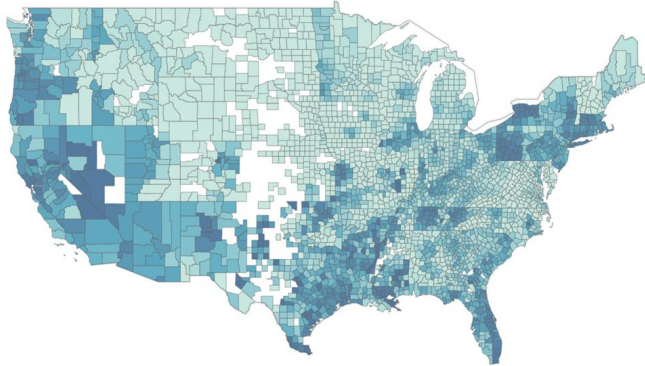
Source: Altarum 2018; Kahn et al. 2005; Yong, Saunders, and Olsen 2010.

Note: BIR refers to billing- and insurance-related expenses. EHR refers to electronic health records. Other providers include pharmacies, labs, and skilled nursing, long-term care, and rehabilitation facilities. Costs are in billions of dollars.

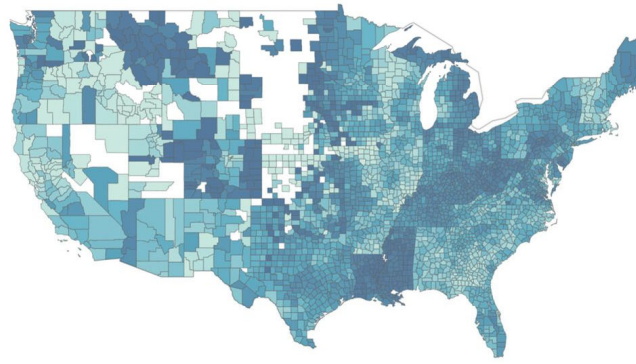
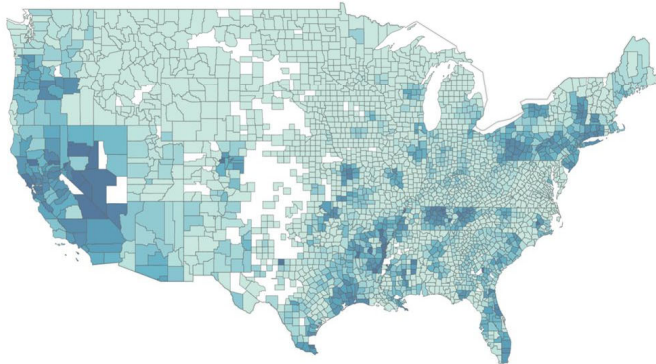


PA in MA grew from 2009 to 2019 but varied widely by location

A. Inpatient acute hospital services



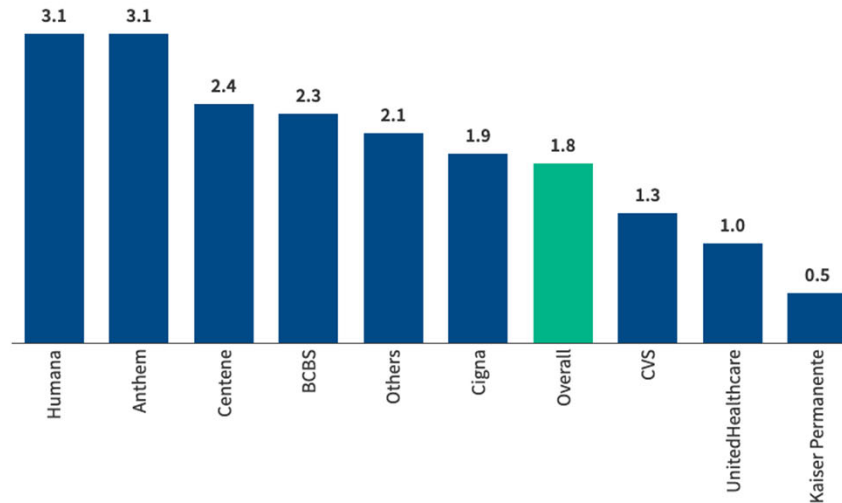
B. Psychiatric services



- **The Extent and Growth of Prior Authorization in Medicare Advantage**
- [Hannah T. Neprash, PhD, John F. Mulcahy, MSPH](#)
- Am Jnl of Managed Care March 2024 Volume30 Issue 3Pages: e85-e92

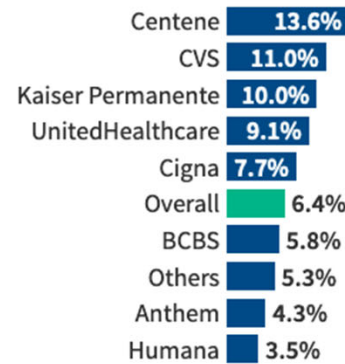
Frequency and denial rates vary by carrier—2023 data

Requests for prior authorization of services per Medicare Advantage enrollee in 2023



Firms Denied Between 4% and 14% of Prior Authorization Requests

Adverse and partially favorable determinations as a share of all prior authorization determinations in 2023



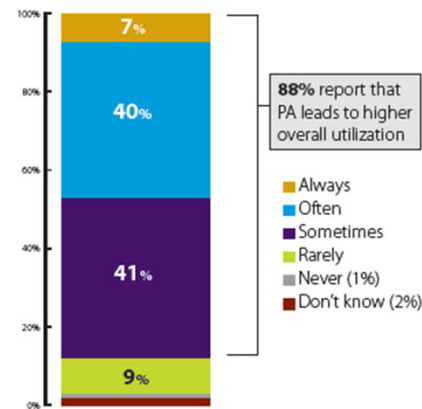
Note: Denied requests include determinations that were partially favorable or adverse. Data for Anthem BCBS is not included because of data quality issues.

Source: Limited Data Set, Contract Year (CY) 2023 Part C and D Reporting Requirements Data • [Get the data](#) • [Download PNG](#)

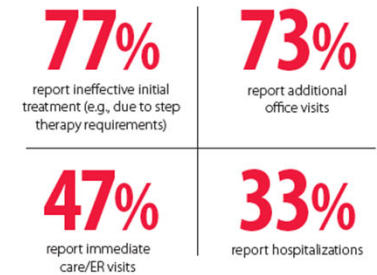
KFF

Docs say PA increases cost and utilization. AMA 2024 MD survey

Q: Please consider how your patients' utilization of health care resources is impacted by the PA process. In your experience, how often does the PA process lead to higher overall utilization of health care resources?

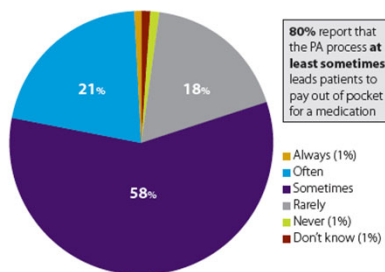


Q: In which of the following ways has the PA process led to higher overall utilization of health care resources for patients in your care?



Patient out-of-pocket costs and PA

Q: How often does a PA delay or denial lead to a patient paying out of pocket for a medication that you prescribe (i.e., the health plan does not cover the prescription and the patient pays the full cost)?

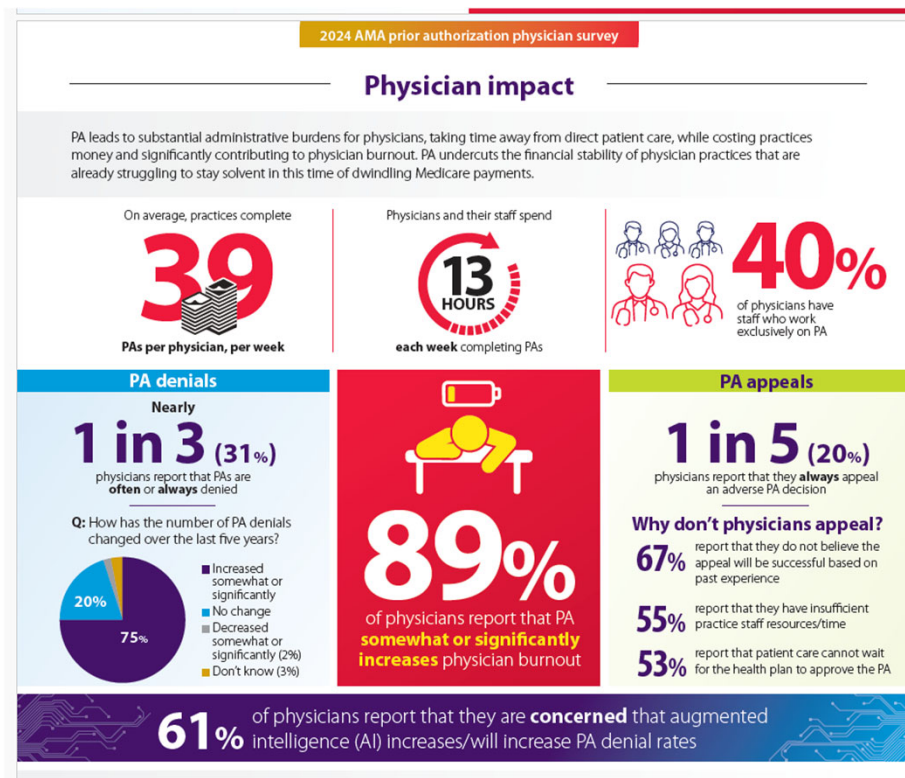


Only respondents who reported completing prescription medication Rx were presented with this question.

Employer impact

58% of physicians with patients in the workforce report that PA has impacted patient job performance

PA costs physicians money, time and energy



PA probably does not reduce total healthcare spending

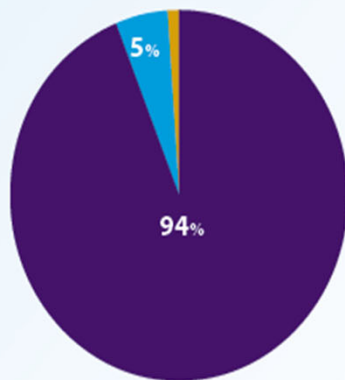
- Total spending equals units of service times price per unit

$$T = U \times P$$

Physicians in 2024 AMA survey reported patient harm from PA

Impact of PA on clinical outcomes

Q: For those patients whose treatment requires PA, what is your perception of the overall impact of this process on patient clinical outcomes?



Almost 1 in 3 (31%) physicians report that PA criteria are rarely or never evidence-based

- Somewhat or significant **negative** impact
- No impact
- Somewhat or significant **positive** impact (1%)



More than 1 in 4 physicians (29%) report that PA has led to a **serious adverse event** for a patient in their care.

23%
of physicians report that PA has led to a patient's hospitalization

18%
of physicians report that PA has led to a life-threatening event or required intervention to prevent permanent impairment or damage

8%
of physicians report that PA has led to a patient's disability/permanent bodily damage, congenital anomaly/birth defect or death

2024 AMA prior authorization physician survey

Selective PA for expensive new drugs may prevent access for those who need it

Extensive/different documentation

Hard to get data — adherence to other meds

Prescribing by specialists—often not available or expensive for patient

High out of pocket costs for patients; genetic testing; high co-pays

Multiple steps of try/fail

- **Prior Authorization Requirements for Proprotein Convertase Subtilisin/Kexin Type 9 Inhibitors Across US Private and Public Payers**[Jalpa A. Doshi, PhD](#), [Justin T. Puckett, BA](#), [Michael S. Parmacek, MD](#), and [Daniel J. Rader, MD](#)[Author Info & Affiliations](#)
Circulation: Cardiovascular Quality and Outcomes [Volume 11, Number 1](#)
<https://doi.org/10.1161/CIRCOUTCOMES.117.003939>

PA denials for post acute care in MA are particularly high

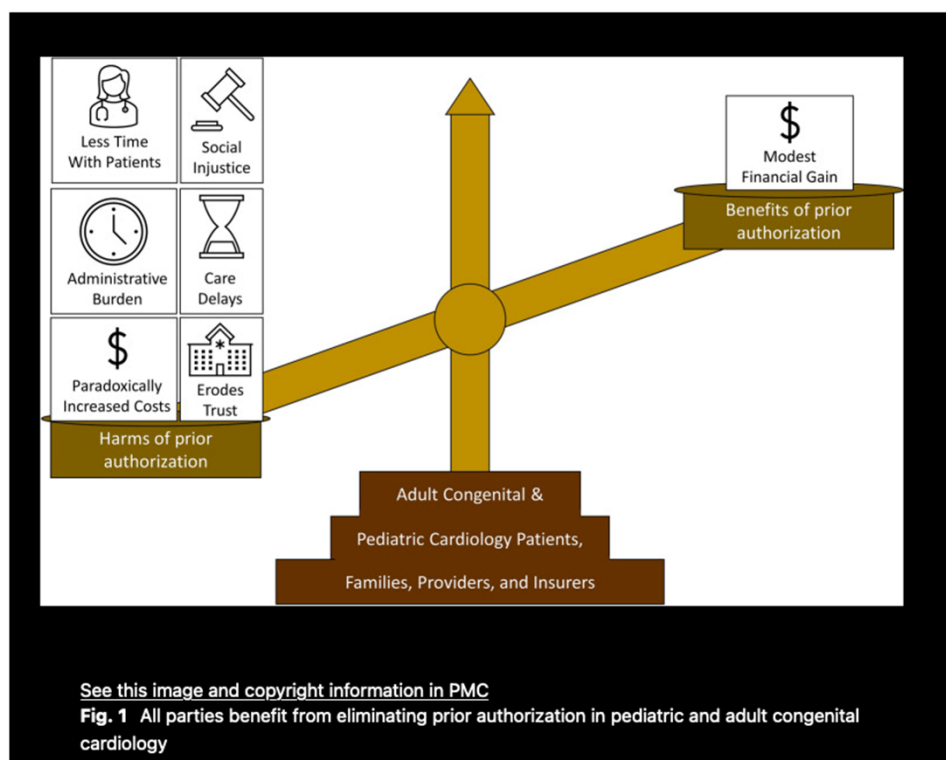
Figure 1: Initial Adverse Determination Rates, Overall and for Post-Acute Care, by Insurer and by Year

Year	UnitedHealthcare		Humana		CVS	
	Overall	PAC	Overall	PAC	Overall	PAC
2019	7.3%	8.7%	1.3%	20.7%	11.6%	24.1%
2020	7.2%	10.9%	1.1%	20.2%	9.5%	24.6%
2021	7.7%	16.3%	1.4%	22.1%	7.3%	24.8%
2022	7.6%	22.7%	1.5%	24.6%	8.8%	25.9%

Sources: UnitedHealthcare New Exhibit A, July 17, 2023; HUM-PSI-0045711-43, HUM-PSI-00457145-48, HUM-PSI-0045750-53, HUM-PSI-0045756-59; CVS-PSI-159396, CVS-PSI-178014, Letter from CVS to PSI, March 29, 2024).



The balance tilts away from cost-benefit of PA



- Marcus BS, Bansal N, Saef J, Fink C, Patel A, Shaffer KD, Mayer JE Jr, Johnson JN, Shaffer K, Chowdhury D. Burden with No Benefit: Prior Authorization in Congenital Cardiology. *Pediatr Cardiol.* 2024 Jan;45(1):100-106. doi: 10.1007/s00246-023-03255-1. Epub 2023 Sep 26. PMID: 37750969; PMCID: PMC10776488.

End Prior Authorization

- See what happens to
 - Total costs
 - Total utilization
 - Patient outcomes/satisfaction
 - Physician income and burnout
 - Carrier profits
 - System complexity



PA not going away; what can/should be done?

- Carrier reform
- Federal reform
- State level reform
 - Other States
 - Hawaii

Carriers are reacting to pressure

Have payers changed tune on prior auth? AMA survey says: Nope [Tanya Albert Henry](#) , Aug 5, 2024



Reducing volume of items requiring PA

United 20%

Cigna 25% on medical care



Speeding/simplifying reviews



Applying automation and AI



Creating "Green cards" for some providers

Federal "final rule" on PA; addresses process; applies to federal insurance program; take effect 2026 and 2027

Uniform APIs for patients, providers and payers

Response: 72 hours for urgent; 7 days for standard

Denial reasons communicated to treating physicians

Metrics submitted to feds and published on plan websites

- List of items requiring PA; %approved, denied, approved after appeal; turnaround times

Feds issued new rules for MA and federal insurance prior approval programs for 2024 and 2025

- Guide for State action?

Utilization Management Committee must approve all criteria

Carrier PA standards only when no traditional Medicare standard is set

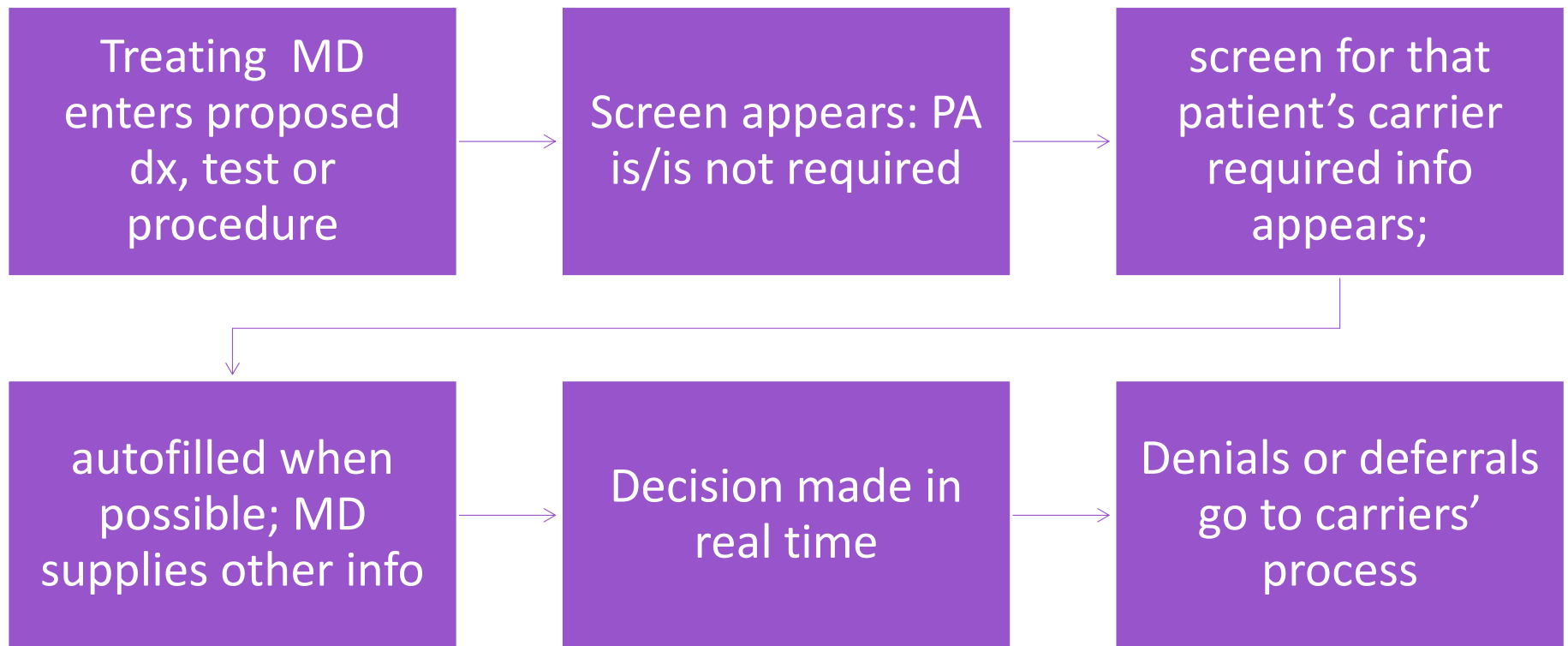
Retroactive denials prohibited

Approval for duration of medically necessary treatment

Grace period of 90 days when switching plans

Gold carding encouraged

Federal rule has idealized picture of how PA will work—The “APIs”



Caution: AI may increase denials

- UH post acute PAC denials from 10.9% in 2019 to 22.7% in 2022 after implementation of automation and AI
- *in April 2021 CVS deployed “Post-Acute Analytics,” which used artificial intelligence to reduce the amount of money spent on skilled nursing facilities. Projected \$77M savings in 3 years*



AMA Publishes State summaries

<https://www.ama-assn.org/system/files/prior-authorization-state-law-chart.pdf>

State	ePA and question set	Response Times	PA length	Retrospective denials	Data reporting	Clinical criteria and medical necessity	Notice of new requirements	Transparency	Qualifications of reviewer	Exceptions/ gold carding	Peer-to-peer/appeal process/ other
HI	General form used by some insurers										
ID	Title 41, Ch. 39 (41-3930)	2 business days after complete member medical information is provided to plan, unless exceptional circumstances warrant a longer period.		Cannot rescind approval of provided service except for fraud/misrep/non-payment of premium, benefit exhaustion, or eligibility.							
IL	Public Act 102-0409	Nonurgent request in 5 calendar days and 48 hours for urgent care 15 days for appeal decisions.	90-day period of authorization when a patients change plans Requires approvals remain valid for six months, and 12 months for chronic conditions and long-term diseases, regardless of changes in dosage	Plans cannot deem as incidental or deny supplies or services that are routinely used as part of a health care service when: (1) an associated health care service has received PA; or (2) PA for the health care service is not required	Statistical reporting requirements include list of services/drugs subject to PA, total # of PA requests received, total # of denials and the top five reasons for denials, the # of denials appeals and whether they were upheld, and the average time between submission and response.	Clinical review criteria must be (1) based on nationally recognized, generally accepted standards except where IL law provides own standard; (2) developed in accordance w/ current standards of a national medical accreditation entity; (3) ensure quality of care and access to needed health care services; (4) evidence-based; (5) sufficiently flexible to allow deviations from norms on a case-by-	Notice of new requirements or changes 60 days in advance	Plan to make any PA requirements including the written clinical review criteria, readily accessible and conspicuously posted on website.	Physician reviewing appeal must: (1) possess a current and valid nonrestricted license to practice medicine; (2) be in the same or similar specialty as one who typically manages condition; (3) be knowledgeable of, and have experience providing, services; (4) not have been directly involved in making adverse determination; (5) consider all known	An issuer must periodically review requirements and consider removal (1) where a drug/ procedure is customary and properly indicated or is a treatment for the clinical indication as supported by peer-reviewed medical publications; or (2) for patients currently managed w/ established treatment regimen.	Denials can be appealed/ reviewed by external independent review.

Key features in State actions

Response Times and PA duration 48 to 72 hours for urgent; 2-5 business days for non-urgent (Illinois, New Jersey, and Minnesota)
Ban Retrospective or Retroactive Denials and Appeals(Arkansas, Louisiana Alaska, Arizona, Illinois)

Mandatory peer-to-peer reviews with appropriate specialists Georgia, New York, Louisiana).

Specific exemptions e.g., ER, Cancer, Mental Health (New Hampshire, Kentucky, New Jersey)

Gold Carding and Exemptions (Texas, Arkansas, Michigan)

Transparency & Data Reporting mandate insurers to report PA requirements and result statistics and post online including denial rates, approval timelines, and appeal outcomes (California, Louisiana, New Jersey Colorado, Indiana, Minnesota)

Peer Review and Medical Necessity Criteria based on evidence (New York, California, Illinois)

Some new State level ideas

Independent
Commission to
administer

Single set of
required PA

Carriers to pay
providers for
information

Carriers fined if
high level of denial
appeals
overturned

Set glide path
toward eliminating
PA

Start with a simple question: What problem are we trying to solve; not how do we fix prior approval

- Reduce low value care?
- Reduce medical spending?
- Protect insurance company stability?
- Reduce provider burden/burnout?
- Reduce complexity?
- Improve equity?
- Improve patient outcomes?
- Strengthen Hawaii health eco-system?



To make recommendations Hawaii workgroup will probably need

What actually happens now—beyond anecdote

- Complete list of procedures, tests, dme etc requiring PA by carrier with frequency
- Results: % approvals, denials, approval on appeal or after extension
- Time for response by category
- Equity; are some groups/locations disproportionately affected by incidence or denials
- Time and money different types of providers spend on PA; money carriers spend

What happened to patients with denials for conditions

Capacity of providers to adopt automated procedures; likely costs

Importance of prior approval savings to insurance company financial stability

Views of patients; employers; unions

Thanks

