BARRIERS TO HEALTH CARE FOR CONSUMERS WITH INSURANCE: PRIOR AUTHORIZATION

Presented By:

Ashley Blackburn,
Health Care for All Massachusetts

Lucy Culp,
The Leukemia & Lymphoma Society

Eric Ellsworth,
Consumers' Checkbook

Carl Schmid
HIV+Hepatitis Policy Institute

NAIC Consumer Liaison Meeting
March 21, 2023

National Association of Insurance Commissioners

The Washington Post
Democracy Dies in Darkness

I wrote about high-priced drugs for years. Then my toddler needed one.

As a health and science reporter, I've studied the maze of U.S. health care. But when my son got sick, I still got lost.

Perspective by Carolyn Y. Johnson
Staff writer

January 30, 2023 at 6:30 a.m. EST

> Put more simply: Health care is a battlefield. Patients often become cannon fodder. I knew all this. I expected it. Still, when our appeal was denied in October, I felt like I had been punched.

The struggle varied, depending on the insurer and the specific drug that the child needed, but it seemed especially cruel in this case, because "there isn't a clear alternative that has a reasonable chance of being effective," said Grant Schulert, a pediatric rheumatologist at Cincinnati Children's Hospital.

PROPUBLICA

UnitedHealthcare Tried to Deny Coverage to a Chronically Ill Patient. He Fought Back, Exposing the Insurer's Inner Workings.

by David Armstrong, Patrick Rucker and Maya Miller

Feb. 2, 5 a.m. EST

Christopher McNaughton sits on the campus of Penn State University. He has been battling United Healthcare for coverage of his treatment for ulcerative colitis. Nate Smallwood, special to ProPublica

After a college student finally found a treatment that worked, the insurance giant decided it wouldn't pay for the costly drugs. His fight to get coverage exposed the insurer's hidden procedures for rejecting claims.

STAT

INSURANCE

Same patient, same drug, same insurer — coverage denied

By Tara Bannow March 2, 2023

The reason the drug was covered in 2014 is because BCBSMA didn't require prior authorization around the use of rituximab for most conditions at the time, Yeats said. Prior authorization means the insurer has to do a clinical review to see whether medical evidence supports coverage. Since then, the company has added specific indications for which it doesn't think there's enough evidence to warrant coverage, FSGS being one of them.

Claims Denials and Appeals in ACA Marketplace Plans in 2021

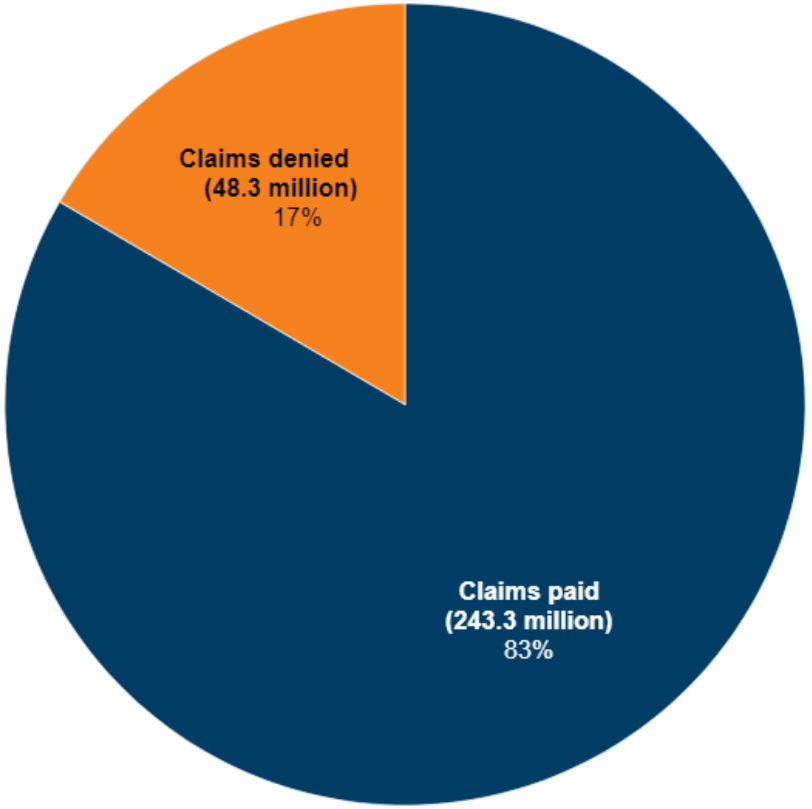
Karen Pollitz , Justin Lo , Rayna Wallace , and Salem Mengistu

Published: Feb 09, 2023

Figure 1

HealthCare.gov Issuers Denied 17% of In-Network Claims in 2021

Share of 291.6 million in-network denied claims



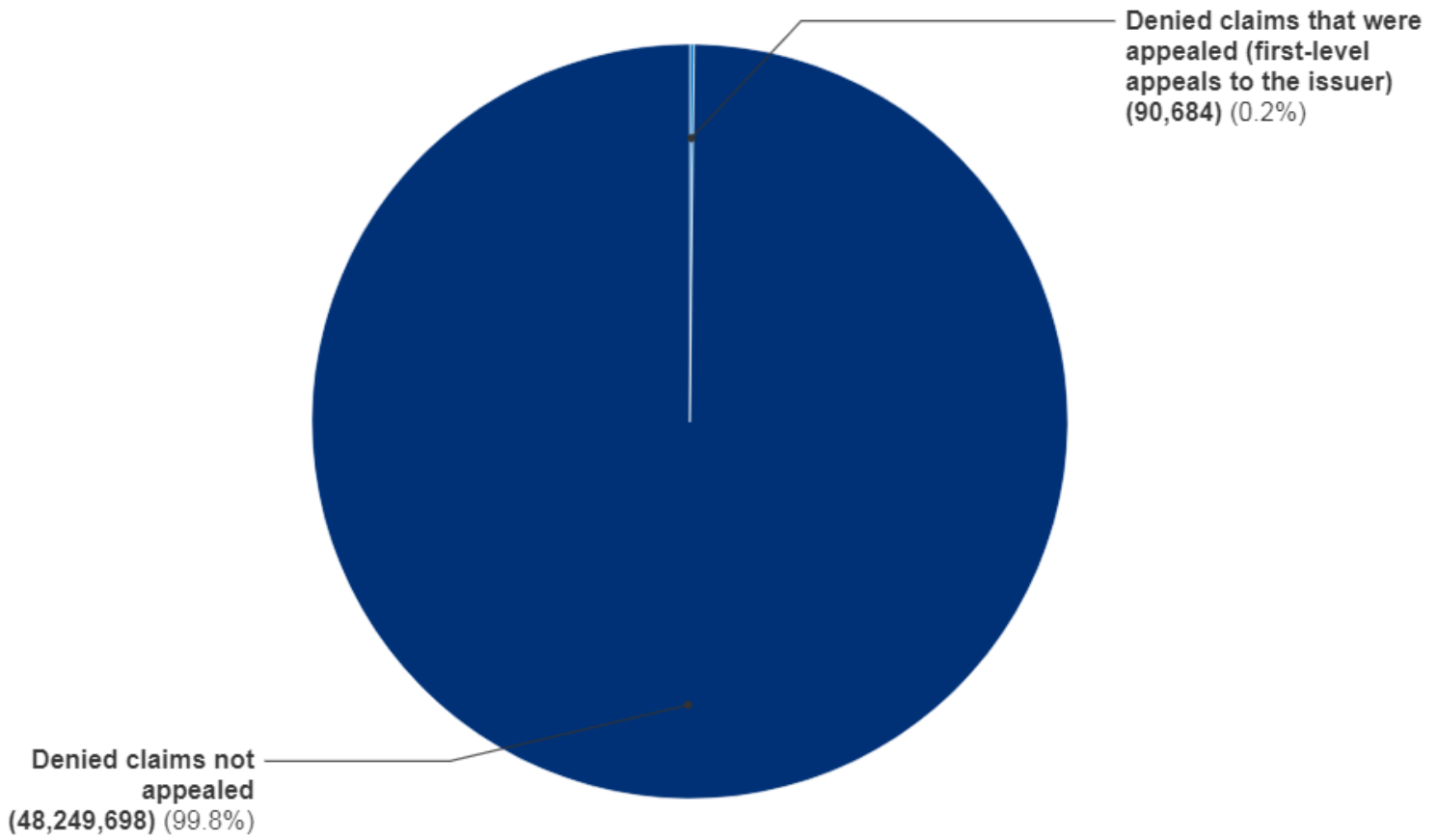
SOURCE: CMS Transparency in coverage data for 2021 plan year • PNG

KFF

Figure 4

Consumers rarely appeal denied health insurance claims

Share of 48.3 million denied claims appealed by consumers in 2021 through internal issuer appeals process



NOTE: This figure only includes denied claims for issuers that show data on appealed claims.
SOURCE: CMS Transparency in coverage data for 2021 plan year. • PNG

KFF

Table 2

QHP-Reported In-Network Denials, by Reason, 2021

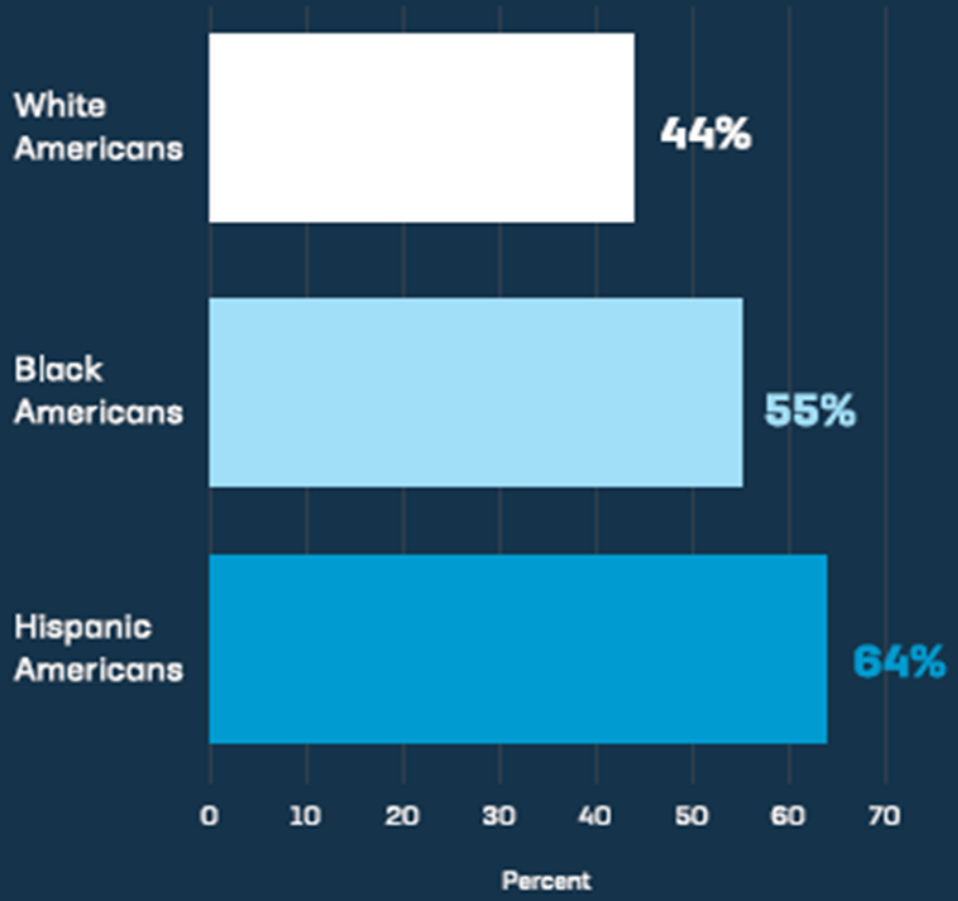
Total In-Network Denials	Denials for Lack of Prior-Authorization or Referral	Denials for Excluded Service	Denials for Medical Necessity (behavioral health)	Denials for Medical Necessity (all other services)	All other reasons
44.7 million	3.6 million (8.0%)	6 million (13.5%)	150,000 (0.3%)	770,000 (1.7%)	34.2 million (76.5%)

SOURCE: CMS Transparency in coverage data for 2021 plan year • PNG

KFF

Source: https://www.kff.org/private-insurance/issue-brief/claims-denials-and-appeals-in-aca-marketplace-plans/

Insurance Practices (Such As Prior Authorization and Fail First) Disproportionately Impact Black and Hispanic Americans



Q: Have any of the following happened to you or your family over the past three months? Please answer regarding any kind of prescription medicine for any condition or illness.
Base: 3,624 Patients who take prescription medicines
Source: Patient Experience Survey, November 30 - December 18, 2021

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531 Hart Senate Office Building
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The Honorable Bernard Sanders
332 Dirksen Senate Office Building
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RE: Inquiry Regarding PrEP and Related Services Coverage

Checks like prior authorization may be in place to ensure that the right patients are getting the right care at the right time, and that valuable resources are not being invested where risks of HIV are low.

Examples of Prior Authorization

- **Arkansas Blue Cross/Blue Shield**
  - Long-Acting PrEP Policy
  - Must have evidence of non-compliance to daily oral PrEP
  - ~~If a woman who can be pregnant must be sterilized or on long-acting birth control~~
    ~~(FDA Label doesn't prohibit Rx use during pregnancy)~~

- **Cigna**
  - Long-Acting HIV Treatment Policy
  - PA requires patient to be virally suppressed 12 and 6 months before start of therapy
  - Must have difficulty maintaining compliance with a daily regimen

Impact of United States pharmacy utilization management techniques on oral antiretrovirals

PRESENTER
David Koren

AUTHORS
D. Koren * (1), B. Packett (2), S. Brawley (2), L. McGorman (2), J. Appelbaum (3), W. Short (4)

INSTITUTIONS
(1) Temple University Health System, Philadelphia, United States, (2) American Academy of HIV Medicine, Washington, United States
(3) Florida State University, Tallahassee, United States, (4) University of Pennsylvania, Philadelphia, United States

- 43% of respondents described required PAs 1-25% of the time for treatment naïve patients.
- 51% of respondents described PAs for medication switches 26-50% of the time.
- Over the last 5 years, 64% of respondents noted an increase in PAs.

Source: https://programme.aids2022.org/Abstract/Abstract/?abstractid=10835

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- Roughly 67% of participants needed dedicated staff for PAs.
- Overall, 72% of participants reported UMTs hindering their ability to prescribe optimal ART therapy.
- 50% described UMTs caused prescribing a less desirable ARV regimen.

Source: https://programme.aids2022.org/Abstract/Abstract/?abstractid=10835

PLOS ONE

RESEARCH ARTICLE

Will prior health insurance authorization for medications continue to hinder hepatitis C treatment delivery in the United States? Perspectives from hepatitis C treatment providers in a large urban healthcare system

Marjan Javanbakht[1]*, Roxanne Archer[1], Jeffrey Klausner[1,2]

1 Department of Epidemiology, Fielding School of Public Health, University of California, Los Angeles, California, United States of America, **2** Division of Infectious Diseases, Department of Medicine, David Geffen School of Medicine at University of California, Los Angeles, California, United States of America

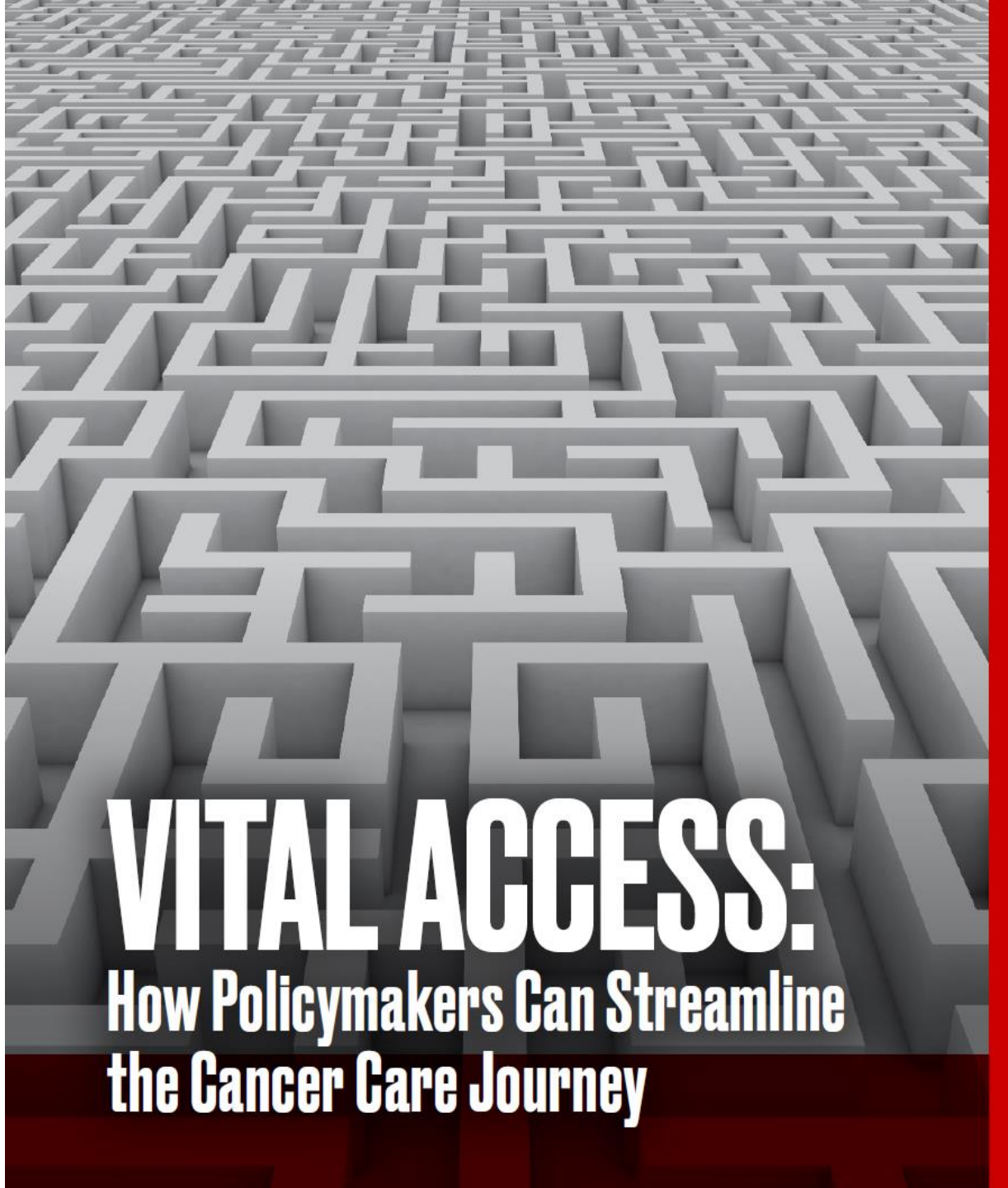
Results

Providers noted that successful HCV treatment delivery was reliant on a care model involving close collaboration between a team of providers, in particular requiring a highly coordinated effort between dedicated nursing and pharmacy staff. The HCV care team overwhelmingly reported that the process of insurance authorization was the greatest obstacle delaying treatment initiation and noted that very few patient level factors served as a barrier to treatment uptake.

Manatt Report for LLS

- Interviews with 25+ insured patients or caregivers who experienced barriers to care
- Documents the “coverage journey” inextricably linked to a patient’s treatment journey
- Offers policy recommendations for state and federal lawmakers

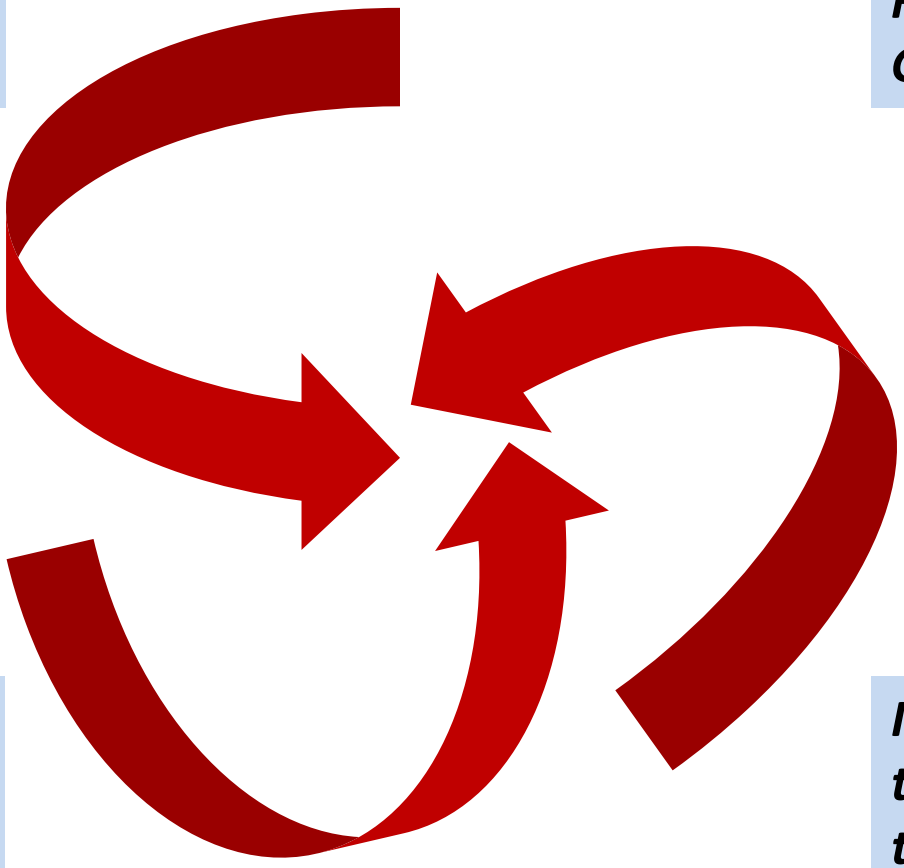
Available at:
https://www.lls.org/sites/default/files/2023-01/vital_access_2023.pdf



Action is Needed By Federal and State Policy Makers

Advances in Science and Proliferation of Effective Therapies for Cancer Patients

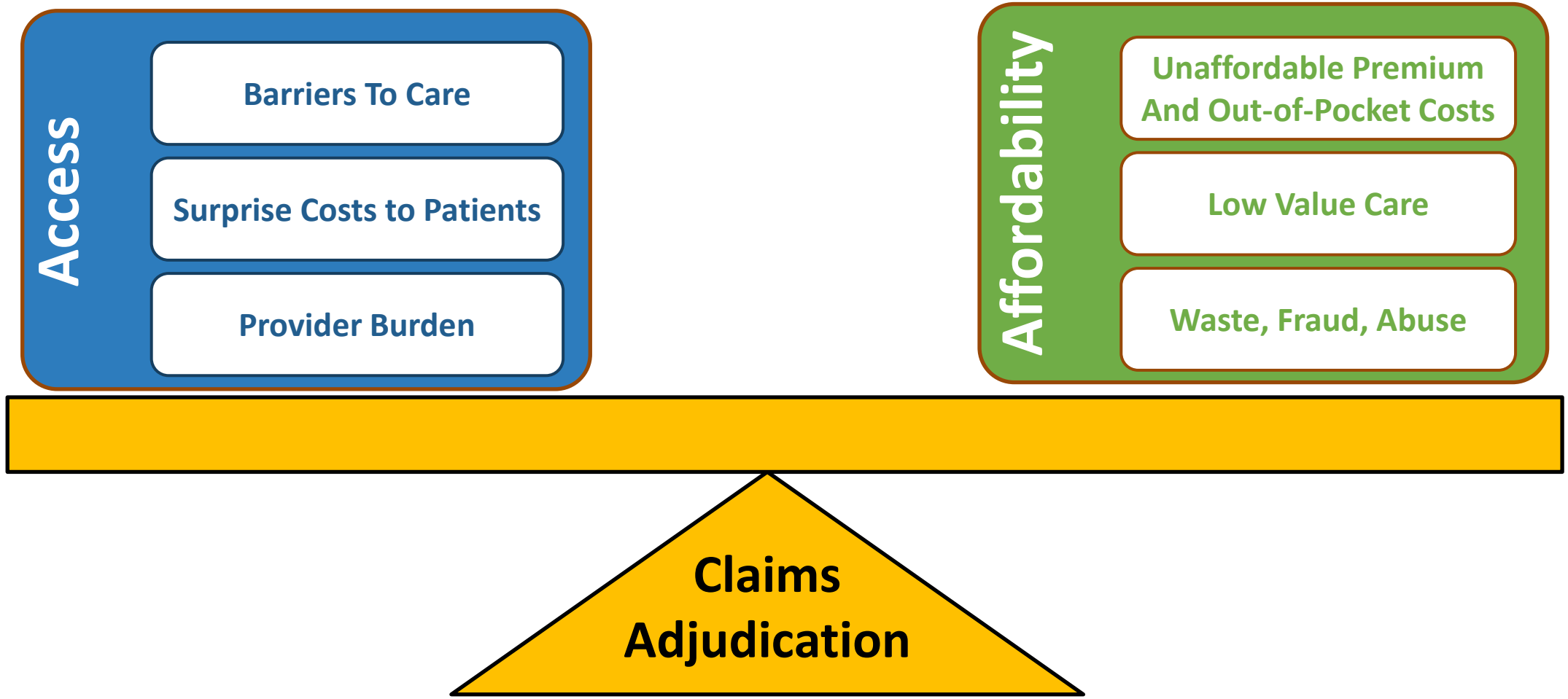
Misaligned and Outdated Regulatory Frameworks Governing Insurance Products



Moral Imperative to Address Systemic Inequities in Access to Health Care Services

Increasingly Sophisticated tools Available to Stakeholders to Better Promote Access

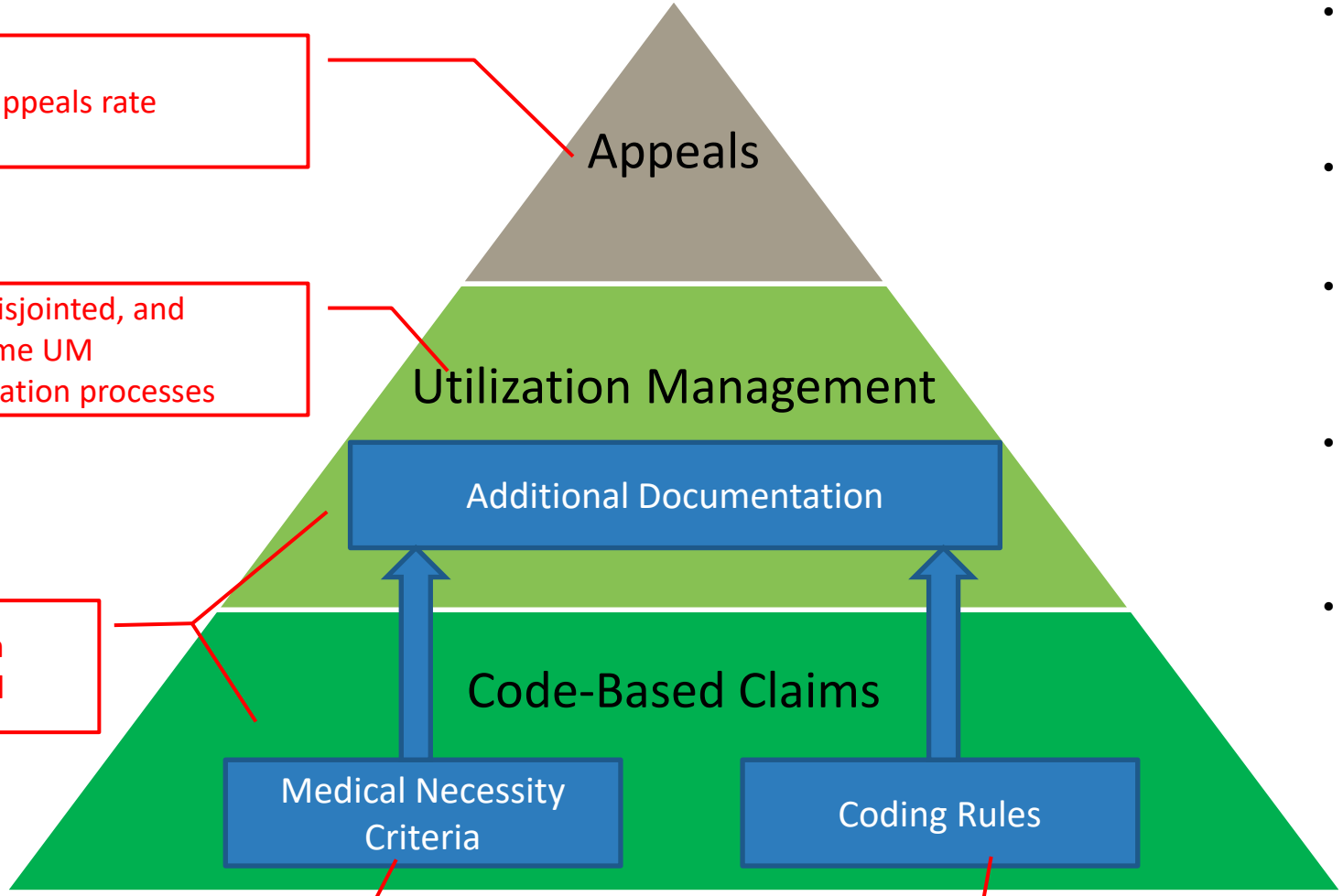
Competing Priorities in Claims Adjudication



Fair, transparent, and effective claims adjudication is essential for US healthcare to be both accessible and affordable

Problems with Current Adjudication Systems

- Very low appeals rate
- Unclear, disjointed, and burdensome UM documentation processes
- Lack of clarity on reason for denial
- Fragmented, non-standard documentation of medical necessity criteria
- Disjointed coding requirements across payers



- Providers can't figure out what will be covered or what the patient will pay
- Consumers cannot shop for coverage of key services
- Patients have no way to know what they'll pay until after claims are adjudicated
- Patients get a stream of baffling and financially threating EOBs and bills
- Poor data on denials hampers oversight/research


HHS Office of Inspector General

The Inability To Identify Denied Claims in Medicare Advantage Hinders Fraud Oversight

03-02-02023 | OEI-03-21-00380 | Complete Report

CMS Rule on Interoperability in Prior Authorization

Patient Access	• Add status of existing prior authorizations, including status for existing years • Prior auth status updates posted w/in 1 business day
Provider	• Allow providers to access claims for their patients • Payers must oversee attribution of patients to providers
Payer-to-Payer	• Transfer member claims from one payer to another upon new enrollment • Allow current payer to assemble better longitudinal record of patient
PAARD (Prior Auth)	• Payers must make prior auth documentation requirements searchable • Does not directly address underlying structure of documentation
Reporting Requirements	• Percentages of services requested, approved denied, expedited vs standard • Time frame of responses and extensions

CMS Rule on Interoperability in Prior Authorization

Authority and Deadlines

- Applies to:
  - QHPs
  - Medicaid/CHIP Managed Care + FFS
  - Medicare Advantage
- Proposed Effective Date of January 1, 2026
- Does not supersede more stringent state laws (esp on timelines)

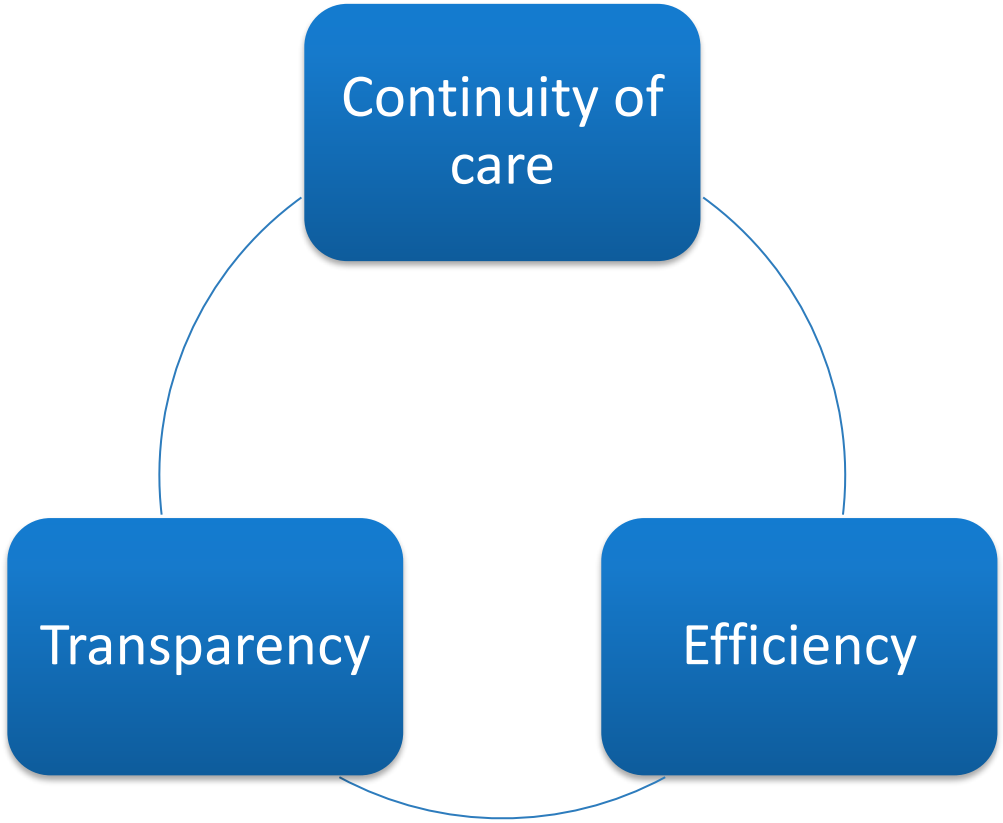
Implementation Considerations

- Builds on FHIR standards
  - FHIR workgroups are eager for stakeholder involvement
- Proof of Concept:
  Documentation Lookup for Medicare FFS
- ONC has software for monitoring these APIs
  - Lantern is open source
  - States can run their own versions

State Action: Massachusetts

An Act Relative to Reducing Administrative Burden

Sen. Friedman & Rep. Santiago (SD.2231/HD. 3720)



Improving Access to and Continuity of Care

- Prohibits prior authorization for:
  - ✓ Generic medications
  - ✓ Medications and treatments with low denial rates, low variation in utilization, or an evidence-base to treat chronic illness
- Requires prior authorization to be valid for the duration of treatment (or at least 1 year)
- Requires insurers to honor a patient's prior authorization from another insurer for at least 90 days

Promote Transparency and Fairness

- Requires public data from insurers as it relates to approvals, denials, appeals, wait times, and more
- Requires the Health Policy Commission to issue a report on the impact of prior authorization on patient access to care, administrative burden, and system cost
- Prohibits retrospective denials if care is preauthorized
- Requires carriers to notify affected individuals about any new prior authorization requirements

Improve Timely Access to Care and Administrative Efficiency

- Establishes a 24-hour response time for urgent care
- Requires insurers to adopt software to facilitate automated electronic processing of prior authorization and the Division of Insurance (DOI) to implement standardized forms

Recommendations for Regulators

- Monitor implementation and compliance with the federal interoperability rule
- Utilize existing authority to monitor carrier conduct
- Support efforts to improve access and continuity of care, including reduced wait times
- Increase public transparency around utilization management, including details of initial and final denials
- Require the use of standard forms and electronic processing
- Require standardization in documentation and publication of medical necessity criteria

Questions