Obstacles to Medically Necessary Care – Part 1: Delays and Red Tape Due to Prior Authorization

Ashley Blackburn (Health Care For All), Lucy Culp (The Leukemia and Lymphoma Society), Eric Ellsworth (Consumers’ Checkbook), and Carl Schmid (HIV + Hepatitis Policy Institute)

March 21, 2023
Barriers to Health Care for Consumers with Insurance: Prior Authorization

Presented By:
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NAIC Consumer Liaison Meeting
March 21, 2023
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.
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.
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

Claims denied (48.3 million) 17%
Claims paid (243.3 million) 83%

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

- Denied claims that were appealed (first-level appeals to the issuer) (90,894) (0.2%)
- Denied claims not appealed (48,249,698) (99.8%)

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
### Table 2
QHP-Reported In-Network Denials, by Reason, 2021

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

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

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

- White Americans: 44%
- Black Americans: 55%
- Hispanic Americans: 64%

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
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
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
- 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
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

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

Misaligned and Outdated Regulatory Frameworks Governing Insurance Products

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.

- Access
  - Barriers To Care
  - Surprise Costs to Patients
  - Provider Burden

- Affordability
  - Unaffordable Premium And Out-of-Pocket Costs
  - Low Value Care
  - Waste, Fraud, Abuse
Systems

Appeals

Utilization Management

Additional Documentation

Code-Based Claims

Medical Necessity Criteria

Coding Rules

• 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 threatening EOBs and bills

• Poor data on denials hampers oversight/research

• 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
# 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*
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