Trends

Statistics and Strategies for Health Plan Sponsors

Third Quarter 2023

Key statistics

Adverse impact of prior authorization (PA) on healthcare

According to an American Medical Association (AMA) survey:

94% of physicians said PA delayed needed care.

46% of physicians indicated PA led to urgent or emergency room visit.

33% of physicians report that PA has led to a serious adverse event for a patient in their care.

Source: 2022 AMA Prior Authorization Physician Survey

Strategies for evaluating PA

PA is intended to control costs and ensure appropriate use of healthcare services. It's become a lightning rod for complaints by doctors, patients and even lawmakers. Done badly, PA can lead to increased plan costs and even adverse health outcomes for plan participants. However, if plan sponsors take a more active role in monitoring how PA is used in their group health plan, PA can achieve good results for the plan's participants.

PA drawbacks

Inefficiencies in the PA process can lead to overutilization of healthcare services as well as patient delays in receiving necessary services. As noted, a recent survey of physicians by the AMA reported unintended outcomes. Areas requiring closer examination include:

- **Delays in care.** One of the most significant harms of PA is the potential for delays in patient care. Requiring healthcare providers to obtain approval from insurance companies before certain treatments, procedures or medications can be provided can lead to delays in accessing necessary care, which can cause potential negative health outcomes for patients, particularly in urgent or time-sensitive situations.
- **Administrative burden.** The PA process can be burdensome for healthcare providers, requiring substantial time and resources to gather and submit the necessary documentation. Physicians may need to complete complex paperwork and spend additional time communicating with insurance companies, diverting their attention from patient care.
- **Increased costs.** While PA aims to control costs, it can also lead to increased administrative expenses for healthcare providers. The staff time and resources required to complete the PA process can be substantial, leading to higher overhead costs. These additional costs may eventually be passed on to patients and contribute to overall healthcare expenses. Another consideration is that if a low-cost drug also has a high approval rate, the cost of PA for that drug may not be worth it.
- **Lack of standardization.** PA requirements can vary significantly among payers and healthcare plans. This lack of standardization adds complexity and confusion for healthcare providers, who must navigate different sets of requirements, forms and criteria. It can lead to inefficiencies and errors, resulting in additional delays and administrative challenges.
- **Adverse health outcomes.** In some cases, PA requirements may lead to patient treatment abandonment. PA can also lead to delaying necessary treatments due to the complexity and time-consuming nature of the process. Conditions may worsen or progress while awaiting authorization.

Segal

- **Inconsistent clinical decision-making.** PA decisions are often made by individuals who may not have direct knowledge of the patient's condition or a comprehensive understanding of the clinical context. This can introduce the potential for inconsistent decision-making, where coverage may be denied even when medically necessary or appropriate.

Evolving landscape

Several reforms and initiatives have been undertaken to improve the PA process.

- **Streamlining and standardization.** For instance, at least 40 states have implemented legislation to establish uniform PA forms and criteria, aiming to simplify the process for healthcare providers and reduce administrative burden. There is proposed federal legislation as well as some states who have passed or are considering legislation allowing providers to earn "gold card" status, exempting them from PA of services after meeting a prior approval rate threshold. UnitedHealthcare, Cigna and Aetna will be revamping their PA programs, including the removal of non-urgent procedures. It remains to be seen if this will impact highly utilized services.
- **Electronic PA (ePA).** The adoption of ePA systems has gained momentum, allowing healthcare providers to electronically submit and track PA requests, reducing paperwork and improving efficiency.
- **Automation and decision support.** Automation and decision support tools have been developed to facilitate PA processes. Artificial intelligence is being employed to automate certain aspects of PA, such as checking formulary coverage, comparing clinical guidelines and identifying potential errors or discrepancies in the submitted requests. Cigna's built-in systems recently resulted in denials that averaged 1.2 seconds per case, raising concerns about use of automation.
- **Expedited or real-time approvals.** Some reforms aim to expedite the approval process for urgent or time-sensitive procedures. Programs have been introduced to allow for real-time or near real-time approvals of certain procedures, reducing delays and ensuring timely access to necessary care.
- **Transparency and appeals process.** Initiatives have been undertaken by CMS to enhance transparency in the PA process. This includes providing clear information to patients and healthcare providers about PA requirements, criteria and expected timelines.
- **ACA and Mental Health Parity and Addition Equity Act (MHPAEA) requirements.** The ACA prohibits use of PA related to emergency services. Under MHPAEA, plans are required to document use of PA for both medical and behavioral health services and provide a comparative analysis with the rationale and evidence in addition to other non-quantitative treatment limitations.

Steps for enhancing PA

To enhance PA, plan sponsors can consider the following steps:

- Engage in value-based payment contracting that encourages better care coordination among providers. When providers work collaboratively, share information and coordinate patient care, it reduces the need for PA for certain services or treatments.
- Request reports from payers to evaluate current rates of denial by type of service with a comparison to norms. Challenge payers to focus PA on conditions driving highest trend.
- Review PA criteria to align with current evidenced-based guidelines and industry standards. In some cases, PA is a useful tool to produce plan cost savings. In other cases, clinical programs that do not support participants who have complex needs and conditions may not save on costs and can result in complications.
- Implement PA rules in drug benefits to optimize patient outcomes that ensure appropriate medications are received, while reducing waste, unnecessary drugs and cost. Utilize PA on high-cost brand drugs that have lower cost therapeutically equivalent generics available.
- Evaluate PA rules for compliance with regulatory changes or updates.
- Educate participants about the process and steps involved, including what services require PA.

Compliance reminder

To stay on top of all the ACA dollar amounts and percentages for group health plans, see our June 8, 2023 insight.

To discuss the implications for your plan of anything covered here, contact your Segal consultant or get in touch via our website, segalco.com.

This *Trends* was published in June 2023. For previous issues of *Trends* or other Segal publications, visit the insights page of our website, segalco.com.

Trends is for informational purposes only and does not constitute legal, tax or investment advice. You are encouraged to discuss the issues raised here with your legal, tax and other advisors before determining how the issues apply to your specific situations.

© 2023 by The Segal Group, Inc.

Segal