601 Pennsylvania Avenue, NW
South Building, Suite 500
Washington, D.C. 20004

T 202.778.3200
F 202.331.7487
ahip.org

April 3, 2024

Senator Virginia Lyons, Chair
Senate Committee on Health and Welfare
115 State Street, Room 17
Montpelier, VT 05633

RE: AHIP Comments on Prior Authorization

To Chairwoman Lyons and Members of the Senate Committee on Health and Welfare,

America's Health Insurance Plans (AHIP) appreciates this opportunity to provide comments on H.766, legislation that would change prior authorization and step therapy requirements, health insurance claims, and reporting requirements for health insurance providers.

AHIP and its members are aligned with the Committee's commitment to increase access to high-quality, affordable health care for everyone in Vermont. We believe these goals are best achieved when the regulations and policies are not overly restrictive, ensuring policies do not inadvertently jeopardize patient safety and increase health care costs for all patients.

Section 3: Prior Authorization Requirements:

Health plans use prior authorization (PA) as an important tool to ensure safe, effective, and evidence-based care for patients and to help prevent over-utilization perpetuated by fraud. The current language in Section 3 limits a carrier's ability to establish prior authorization criteria based on the most up-to-date clinical guidelines so that patients are receiving the most appropriate and efficient care to produce positive health outcomes. We understand the intention is to reduce variability in prior authorization requirements by mandating alignment of the requirements with Vermont's Medicaid program. We are committed to working with our provider partners to streamline the PA process; however, this well-intended approach is wrong for patients. Section 3 will be incredibly costly for Vermont's consumers and small businesses.

AHIP respectfully requests that Section 3 be removed from H.766 in its entirety. Aligning PA requirements with the Medicaid program does not take into consideration the different patient populations and utilization trends that exist between the Medicaid and commercial markets. AHIP recommends the Committee consider an alternative approach. Some states have adopted similar laws setting standards for prior authorization requirements to ensure those clinical standards are evidence-based. For example, criteria based on the clinical recommendations of a professional society using evidence-based research allows prior authorization to be reflective of the most recent data available and the needs of patients.

Prior Authorization Ensures Safe, Effective, and Cost-Efficient Health Care for Patients:

PA is used when there are clinical deviations in the standard of care and protects patients from unnecessary care and increased costs. While studies have shown many providers provide care

consistent with evidence-based standards,[1] health plans utilize PA to ensure *all patients* are receiving the safest, most effective care consistent with the current medical research and data.

Health insurance plans continue to collaborate with health care providers and other stakeholders to implement innovative solutions to improve the prior authorization process. Despite that intentioned collaboration, thirty percent of all heath care spending in the United States may be unnecessary, and in many cases harmful to patients. Indeed, every year low-value care costs the U.S. health care system $340 billion. In addition, providers also want to ensure patients are getting proven, high value care. Health insurance plans focus on ensuring patients get the right care, at the right time, in the right setting, and get that care at a cost patients can afford. Insurers are uniquely positioned to have a holistic view of a patient's health care status and thus use PA as an effective tool that helps to lower a patient's out-of-pocket costs, protects patients from overuse, misuse or unnecessary (or potentially harmful) care, and ensure care is consistent with evidence-based practices before care is delivered.) care, and ensure care is consistent with evidence-based practices before care is delivered.

When providers and plans work together, the patient benefits with better outcomes and less financial burden. Health insurance carriers continue to innovate and collaborate with providers and other stakeholders to implement solutions to promote evidence-based care and improve the prior authorization process. Examples include:

- Streamlining prior authorization for complete courses of treatment for musculoskeletal and other conditions.
- Promoting electronic prior authorization requests and decisions.
- Providing feedback to health care providers on their performance relative to their peers and professional society guidelines.
- Waiving prior authorization for providers with a demonstrated track record in practicing evidence-based care.

It is important to understand that PA promotes the appropriate use of medications and services by helping confirm that those medications or services do not interfere with other types of medications or potentially worsen existing conditions. This includes verifying medications are not co-prescribed that could have dangerous, even potentially fatal, interactions. Additionally, PA helps to ensure medications and treatments are safe, effective, and appropriate. Furthermore, it provides guardrails to help ensure drugs and devices are not used for clinical indications other than those approved by the Food and Drug Administration or those supported by medical evidence. And finally, it helps ensures that patients with a newly prescribed medication or course of treatment will receive accompanying services such as counseling, peer support, or community-based support, as appropriate.

Prior authorization aims to help support providers. The amount of medical knowledge doubling every 73 days and primary care providers would have to practice 27 hours per day to keep up their latest guidelines.[2] And according to another study from the Journal of Internal Medicine, primary care providers would have to practice medicine for nearly 27 hours per day to keep up with the latest guidelines.[3] Thus, PA helps providers ensure they are adhering to the most up-to-date evidence-based standards.

Even with these fast-paced innovations, health insurance carriers use PA sparingly, with the percentage of covered services, procedures, and treatments requiring PA less than 15%.[4] In a survey of health

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[1] *Clinical Appropriateness Measures Collaborative Project.* America's Health Insurance Plans. December 2021. https://www.ahip.org/documents/AHIP_AppropriatenessMeasures_2022.pdf.
[2] Densen, Peter. *Challenges and Opportunities Facing Medical Education*. Transactions of the American Clinical and Climatological Association 2011. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3116346/.
[3] Porter J, Boyd C, Skandari MR, Laiteerapong N. *Revisiting the Time Needed to Provide Adult Primary Care.* Journal of General Internal Medicine. January 2023. https://pubmed.ncbi.nlm.gov/35776372.
[4] *Prior Authorization: Selectively Used & Evidence-Based: Results of an Industry Survey.* America's Health Insurance Plans. https://www.ahip.org/wp-content/uploads/Prior_Authorization_Survey_Infographic.pdf.

insurance providers, 73% reported that initial prior authorization requests are denied because the requested procedure or medication is not clinically appropriate for the patient based on medical literature or clinical guidelines. On appeal, 91% of insurers report that a denial is for failure to follow medical literature or clinical guidelines.[5]

Health Insurance Providers Are Committed to Working with Providers to Streamline the Prior Authorization Process.

It is important to note that PA programs are collaborative – health insurance providers use provider input to help ensure treatment plans are protecting patient safety, improving outcomes, and controlling costs. In this spirit, in January 2018, AHIP, together with providers and hospitals, issued a joint consensus statement.[6]

Recent surveys show health plans are waiving or reducing PA requirements; between 2019 to 2022, the percentage of plans waiving or reducing PA based on participation in risk-based contracts increased from 25% to 46% for medical services, and from 5% to 8% for prescription medications.[7]

We encourage the use of electronic authorization (ePA), but this will only work when providers are also required to utilize ePA systems. Even though almost all health insurance carriers offer ePA, 60% of PA requests for medical services, and over a third of PA requests for medications are submitted manually by providers through phone or fax.[8]

As plans continue to take additional steps with encouraging ePA, the 2019 CAQH (Council for Affordable Quality Healthcare) Index conducted a study to measure progress in reducing the costs and burden associated with administrative transactions finding of the $350 billion dollars spent on healthcare administrative costs in 2019, $40.6 billion was spent on administrative transactions and the health care market could have saved $13.3 billion by automating utilization management tools.[9] Therefore, AHIP recommends stakeholders consider exploring available pathways to increase provider adoption of electronic prior authorization technology.

Earlier this year, the Centers for Medicare & Medicaid (CMS) released the Advancing Interoperability and Improving Prior Authorization Processes final rule which requires plans in federal programs to build and maintain three new application programming interfaces (APIs): 1) to enable electronic prior authorization, 2) to share large-scale population health data files with providers for value-based care, and 3) to support coordination of care when a patient moves from one payer to another. Industry and health care stakeholders are in the process of analyzing this nearly 900-page rule. We look forward to having additional discussions through our state partners on this important development.

Section 6 &7: Insurer and Provider Impact Studies & Reporting Requirements:

We understand the interest of the Legislature to receive impact reports from insurers and providers (Sections 6 and 7, respectively). Insurers are *required* to submit reports to the Legislature on the impacts

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[5] *Key Results of Industry Survey on Prior Authorization*. AHIP. June 8, 2020. https://www.ahip.org/resources/key-results-of-industry-survey-on-prior-authorization.

[6] *Consensus on Improving the Prior Authorization Process*. American Hospital Association, America's Health Insurance Plans, American Medical Association, American Pharmacists Association, Blue Cross Blue Shield Association, and Medical Group Management Association. Available at https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc-public/prior-authorization-consensus-statement.pdf.

[7] *Improving Prior Authorization Processes: How Health Insurance Providers Are Delivering on their Commitments.* America's Health Insurance Plans. https://www.ahip.org/documents/202207-AHIP_1P_Consensus_Statement_Actions-v02.pdf.

[8] *Id.*

[9] *2019 CAQH Index.* CAQH. https://www.caqh.org/news/caqh-2019-index-133-billion-33-percent-healthcare-administrative-spend-can-be-saved-annually.

of PA, while only *requesting* such reports from providers. For the impacts of prior authorization to be fully studied, we ask providers to have a shared responsibility with insurers in submitting data. Without such requirements, the data electively submitted by the provider population does not give a complete view of the provider experience and risks outliers having an outsized impact on any future policymaking if only a select few, with potentially extreme experiences, submit impact reports.

Additionally, we request any reporting be submitted to the Department of Financial Regulation (DFR) as our regulator. DFR should be granted the authority to establish reporting criteria for insurers and providers to ensure data submitted is consistently measured and easily compared.

Thank you for your consideration of our comments. AHIP and its members stand ready to work with Vermont on this critical issue. We hope AHIP can be a resource for you as the Committee considers legislation that impacts the ability for health carriers to employ utilization management tools while providing access to care producing high quality outcomes. If you have any questions or concerns regarding our comments and would like to discuss these matters further, please contact Sarah Lynn Geiger at slgeiger@ahip.org or by phone (609) 605-0748.

Sincerely,

Sarah Lynn Geiger, MPA
Regional Director, State Affairs

AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and coverage more affordable and accessible for everyone. Visit www.ahip.org to learn how working together, we are Guiding Greater Health.