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February 26, 24

House Health & Social Services Committee
Alaska State Legislature
Juneau, Alaska 99801

**Re: AHIP Concerns on HB 187, *Prior Auth for Exempt Health Providers***

Dear Chair Prax, Vice Chair Ruffridge, and Members of the Committee,

On behalf of AHIP, I am writing to respectfully express our opposition to HB 187, legislation that requires health plans to exempt certain providers from having to complete the prior authorization (PA) process through what is known as gold carding programs.

We are aligned with the Committee's commitment to increase access to high-quality, affordable health care for everyone in Alaska. However, we believe these aims are best achieved when the policies are not overly restrictive, as that could inadvertently harm patient safety and increase health care costs for all patients.

***Prior authorization is critical to ensuring safe, effective, and cost-efficient health care for patients.***

Health plans are focused on ensuring that patients get the right care, at the right time, in the right setting, and covered at a cost that patients can afford. Insurers are uniquely positioned to have a holistic view of a patient's health care status and use prior authorization 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.

PA is a proven tool that ensures patients get the most up to date evidence-based care and prevents clinical deviations that could adversely impact patients. Health plans collaborate with providers and other stakeholders to implement innovative solutions to improve the PA process. However, the need for PA is evident; 30% of all heath care spending in the U.S. may be unnecessary, and in many cases harmful to patients.[1] Every year low-value care costs the U.S. health care system $340 billion.[2] Further, 87% of doctors have reported negative impacts from low-value care.[3]

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[1] *Waste in the US Health Care System*. Shrank, William H. JAMA. October 2019. https://achp.pub/JAMA-LVC.

[2] *Low-Value Care*. University of Michigan V-BID Center. February 2022. https://achp.pub/VBID-Low-Value-Care.

[3] *Characteristics of Low-Value Services Identified in US Choosing Wisely Recommendations*. Ganguli, Ishani. JAMA Internal Medicine, February 1, 2022, https://achp.pub/Low-Value-Study-2022.

PA also promotes the appropriate use of medications and services by helping to confirm that they do not interfere with other types of medications or potentially worsen existing conditions. This includes verifying that medications are not co-prescribed in a manner that could have dangerous, even potentially fatal, interactions. Additionally, PA helps to ensure that medications and treatments are safe, effective, and appropriate. Furthermore, it provides guardrails to help ensure that drugs and devices are not used for clinical indications other than those approved by the Food and Drug Administration or those that are supported by medical evidence. And finally, it helps to ensure 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.

PA clinical criteria are evidence-based, developed by nationally recognized entities, and help to ensure providers are adhering to the most up-to-date evidence-based standards. The importance of utilization management tools such as PA cannot be understated, a recent study found that the amount of medical knowledge ***doubles every 73 days***.[4] 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.[5]

Even with the fast-paced growth of medical knowledge, health plans use PA sparingly, with the percentage of covered services, procedures, and treatments requiring PA around less than 15%.[6] Of that, health insurance providers report that up to 30% of PA requests they receive from clinicians are for unnecessary care that is not supported by medical evidence.

***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 2018, AHIP, together with providers and hospitals, issued a joint consensus statement to cooperatively improve the PA process.[7] Since then, health insurance providers have taken

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[4] 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/.

[5] 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.

[6] *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.

[7] *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.

several extensive steps to improve the prior authorization for patients and providers alike. Examples include:

- Streamlining prior authorization for complete courses of treatment for musculoskeletal and other conditions.
- Promoting electronic prior authorization (ePA) 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.

In January 2020, AHIP along with two technology partners and several member insurance providers, launched the Fast Prior Authorization Technology Highway (Fast PATH) initiative to better understand the impact of electronic prior authorization on improving the prior authorization process.[8] AHIP's Fast Path study shows:

- 60% of experienced users (providers) said electronic prior authorization made it easier to understand if prior authorization was required.
- The median time between submitting a prior authorization request and receiving a decision from the health plan was more than three times faster, falling from 18.7 hours to 5.7 hours in processing time – a 69% reduction.

Health care experts and clinical leaders have also called for wider adoption of evidence-based guidelines. The mission of the Choosing Wisely Initiative[9] – which was founded by physicians and clinicians – is to help inform patients and ensure that any test, treatment, drug or procedure is "supported by evidence, not duplicative of other tests procedures, free from harm, and truly necessary." That is what prior authorization delivers.

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 exchanged across the medical and dental industries.[10] During this study, CAQH found 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. Therefore, AHIP recommends stakeholders consider exploring available pathways to increase provider adoption of electronic prior authorization technology.

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[8] *Prior Authorization: Helping Patients Receive Safe, Effective, and Appropriate Care.* America's Health Insurance Plans. https://www.ahip.org/prior-authorization-helping-patients-receive-safe-effective-and-appropriate-care. ,

[9] https://choosingwisely.org/

[10] *2019 CAQH Index.* CAQH. https://www.caqh.org/news/caqh-2019-index-133-billion-33-percent-healthcare-administrative-spend-can-be-saved-annually.

On January 17, 2024, 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 four 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, 3) allow patients to more easily access their claims and clinical data, and 4) to support coordination of care when a patient moves from one payer to another. Industry and health care stakeholders are analyzing this nearly 900-page rule. We look forward to having additional discussions through our state partners on this important development.

## Gold Carding

Similar to HB 187, we are seeing many legislative approaches attempting to restrict prior authorization through gold carding programs nationally, and we caution legislative initiatives that take this approach. HB 187 requires health insurers to establish gold carding programs for health care providers or groups of providers with an authorization rate in the 80th percentile over the most recent 12-month period.

***Broadly waiving PA and mandating gold carding programs could lead to clinically inappropriate care, exposing patients to potential harm by using a service or drug where there is little to no evidence of clinical benefit, and could raise costs for all consumers and purchasers.***

Patients should expect to receive safe and appropriate care 100% of the time, period. Prohibiting PA eliminates checks on unnecessary care. Health plans report that up to 30% of PA requests they receive from clinicians are for unnecessary care that is not supported by medical evidence.[11] This in turn will significantly limit a health plan's ability to ensure health care dollars are used most efficiently to produce high quality health outcomes, effectively ending provider accountability for fraud, waste, and abuse.

Eliminating PA by mandating broad gold carding programs will significantly and negatively impact the state's health care system. Through Texas' experience with the implementation of its gold carding law, HB 3459 which passed in 2021, we now have a better picture of these impacts. ***The law is estimated to increase premiums for small businesses and individuals by more than $1 billion annually in the fully insured market alone.***[12] ***Just one health plan estimates that the***

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[11] *Prior Authorization: Helping Patients Receive Safe, Effective, and Appropriate Care.* America's Health Insurance Plans. https://www.ahip.org/prior-authorization-helping-patients-receive-safe-effective-and-appropriate-care.

[12] *Veto Letter Request to Governor Abbot on HB 3459.* Texas Association of Health Plans. June 3, 2021.

***gold carding mandate will cost consumers $500 million a year to end prior authorizations – a figure that is estimated for just its members.***[13]

Another Texas plan used back surgeries as an example of a procedure that is a high-cost intervention for medical issues that could potentially benefit from less extreme, and more affordable, care delivery approaches to highlight the cost impacts of the gold carding mandate.[14] Under the law, employers would have to pay 100% for back surgeries, even though they are inappropriate at least 10% of the time. ***The claims for this one procedure alone would cost the plan $150 million a year.***

Furthermore, a Milliman study found that eliminating PA could increase premiums by $20.1 - $29.52 PMPM – a total increase of $43 - $63 billion annually in the commercial market nationwide.[15] When providers know they are being monitored, their performance tends to improve. Removing PA cuts out the one party that has the fullest view of patient care and that understands contraindications. As a result, health insurance providers have reported increased utilization when gold carding programs are put into place.

We are also concerned about the administrative difficulties of operationalizing gold carding programs which causes further confusion and frustration for providers and patients. Again, using Texas as an example, while the law had an effective date of January 1, 2022, implementation was delayed due to a particularly cumbersome rulemaking process.

Gold carding programs are most effective when provider performance is closely monitored because they are not appropriate for all providers and all services. Gold carding programs should:

- Be targeted to specific services and where provider performance can be regularly reviewed.
- Separate out prescription benefits from the medical benefits to allow for more tailored review processes and allow health plans and their PBM partners to fully utilize the safety and efficacy tools already in place to protect patients and consumers from harmful and costly drugs.
- Allow health insurance providers to monitor providers participating in these programs to ensure that the provider's standard of practice is consistent with the standard of safe, timely, evidence-based, affordable, and efficient care.

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**13** *Id.*

14 *Id.*

15 Busch, Fritz S. and Stacey V. Muller. *Potential Impacts on Commercial Costs and Premiums Related to the Elimination of Prior Authorization Requirements*. Milliman Report. March 30, 2023. https://www.milliman.com/-/media/milliman/pdfs/2023-articles/8-18-23_bcbsa-prior-authorization-impact.ashx.

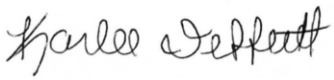
- Allow insurers to revoke a provider's participation in a gold carding program if a provider is not following those standards.[16]

These guardrails are necessary to ensure that providers who receive gold card privileges continue to deliver consistent patterns of high performance to the patients they serve. Health plans need flexibility in operationalizing these programs to keep up to date with medical and safety innovations.

Lastly, the requirements in Section 21.07.100 (g) limiting who can perform peer review to Alaska-licensed providers will unnecessarily prolong the review process and will ultimately add significant costs to customers and patients. Alaska does not have an adequate number of licensed providers in every specialty to make compliance feasible, especially given the rural nature of the state. In order to reduce costs and ensure that reviews can be performed comprehensively in an appropriate period of time, AHIP respectfully requests that qualified reviewers regardless of their state of licensure be allowed as they apply to the same or similar specialty for that diagnosis or treatment under review.

For these reasons, AHIP respectfully requests that the House Health & Social Services Committee not support HB 187. We appreciate the opportunity to provide feedback on the legislation and your consideration of our concerns.

Sincerely,



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16 *New Survey: Effective Gold Carding Programs are Based on Evidence and Value for Patients.* America's Health Insurance Plans. July 19, 2022. https://www.ahip.org/resources/new-survey-effective-gold-carding-programs-are-based-on-evidence-and-value-for-patients.