aetna®

April 8, 2024

Senator Jesse Bjorkman
Alaska State Legislature
State Capitol Room 9
Juneau, AK 99801

Re: Senate Bill 219

Dear Senator Bjorkman, Chair Senate Labor and Commerce Committee:

Thank you for the opportunity to comment on Senate bill 219 regarding prior authorization. We have significant concerns that the bill will detrimentally impact Alaskans by lowering the quality of care they receive, increasing the costs they pay, and failing to change the administrative efficiency for providers rendering care.

CVS Health serves millions of people through our local presence, digital channels, and our nearly 300,000 dedicated colleagues – including more than 40,000 physicians, pharmacists, nurses, and nurse practitioners. Our unique health care model gives us an unparalleled perspective on how systems can be better designed to help consumers navigate the health care system – and their personal health care – by improving access, lowering costs, and being a trusted partner for every meaningful moment of health. We utilize that experience in our Aetna insurance products that cover thousands of Alaskans, and it is with that background and experience that we provide the following feedback in opposition to Senate bill 219.

Prior authorization is a standard industry-wide practice among health plans that determines if certain care is necessary for each individual's situation and adheres to clinical guidelines, regulations, and evidence as set forth in criteria sets. It has played a critical role in the health care industry since the 1960s, and data shows it reduces unnecessary care and helps manage costs. When we receive a prior authorization request for an Aetna member, licensed clinicians carefully assess the clinical situation and then approve or deny the request based on evidence-based criteria sets, plan benefits, regulatory requirements, more than 800 publicly available Clinical Policy Bulletins with the latest peer-reviewed medical studies and expert guidance (reviewed and updated on an ongoing basis), and other industry standard evidence-based guidelines. It is not an arbitrary process, and it helps ensure that patients receive the right care at the right time.

Senate bill 219 ignores the long-standing benefits of prior authorization and instead requires a one-size-fits-all exemption process. No Alaskan would willingly agree to having the quality, safety, or costs of their healthcare disregarded one out of every five times they enter a provider's office or pick up a prescription, but this proposal does just that. By mandating that all providers with an eighty percent approval rating receive a twelve-month

exemption, the proposal utilizes a blunt and misguided solution to a much more nuanced problem. Equally important, the bill assumes that past behavior with one set of patients indicates that future patients, with their own unique set of medical needs, do not deserve the same level of quality and patient safety assurance.

We know the prior authorization process is not without its burdens and frustrations, particularly for providers. We understand the underlying sentiment of why Senate bill 219 was introduced, however misguided its approach may be. As such, over the past few years, Aetna has worked diligently to improve the process by making it simpler and faster. Our actions include:

- Reducing the number of health care services and prescription drugs that require prior authorization. In recent years we reduced the annual number of prior authorization requests by 100,000 for Aetna's privately insured members. We are also reducing the number of requests needed by encouraging providers to submit one prior authorization request for an entire treatment plan, so providers do not need to submit a separate request for a prescription drug when accompanying medical services are already approved. Although each situation is unique, prior authorizations generally remain in effect until the end of a defined service or treatment, for six months for surgeries and one year for chronic or ongoing services.
- Removing some prior authorization requirements for more than 1,000 providers and/or facilities through our Provider Differentiation program, which rewards selected providers that meet Aetna's standard for consistently high performance through prior authorization exemptions.
- Providing automated real-time data exchange between Aetna and CVS Caremark (our PBM), and provider offices. For example, Aetna partners with the CVS pharmacy team to ensure the Clinical Policy Bulletins reflect the latest clinical policy based on FDA-approved indications, comprehensive knowledge, and relevant evidence-based clinical practice.
- Automating approval of services most likely to be approved after clinical review. This automation process generates real-time approvals when criteria sets are met for certain health services and prescription drugs. Clinician review remains essential for other services. In these cases, Aetna's prior authorization requests are reviewed by an appropriately licensed medical practitioner who specializes, as needed, in a field related to the condition, clinical specialty, service, or treatment being reviewed.

As seen above, we know that the prior authorization system needs improvement, and we are doing just that. Many of the actions above, particularly regarding automated approvals for certain services, are more effective than a blanket exemption given that the data exchanged is related to a particular individual who is still at the center of the process. Providers are also alleviated from the confusion of remembering various exemption statuses across multiple insurers and product lines, but still benefit from real time request approval. Recent technology initiatives helped automate an estimated one-third of approved utilization management cases by the end of 2023, in addition to improving access to status updates and notifications that make the process more transparent. Finally,

recently finalized federal rules require health plans to establish and “interoperable” prior authorization system, that will essentially allow for real time data sharing from electronic health records and thereby enable more real time prior authorization decisions.

Now is not the time for Alaska to take a step back and eliminate effective tools such as prior authorization. Instead, it is the time for improving upon existing systems and Aetna will continue to do just that. Health care is about improving people’s health and quality of life. We consider clinical quality and patient safety as core to our prior authorization goals, and we will keep getting better at it. We would be happy to further explore policy ideas that promote the positive momentum already underway. However, Senate bill 219 is a step in the wrong direction, and we respectively ask for your opposition.

Sincerely,

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