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Health and Human Services Committee
Minnesota Senate
95 University Ave. West,
Saint Paul, MN, 55155

Re: AHIP Comments Opposing SF 3532

Dear Chair Wiklund, and members of the committee,

AHIP and our members appreciate the opportunity to respectfully express our opposition to SF 3532, legislation that, among other things, requires health insurance providers to exempt certain providers from having to complete the prior authorization (PA) process through what is known as gold carding programs and implement application programming interfaces (APIs).

We are aligned with the Committee's commitment to increase access to high-quality, affordable health care for everyone in Minnesota. 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.

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 insurance providers collaborate with health care 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 United States 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]

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

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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.

Health insurance providers 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.

When providers and health plans work together, the patient benefits with better outcomes and less financial burden. Health insurance providers 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 (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.

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

[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/.

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 insurance providers 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 this spirit, in January 2018, AHIP, together with providers and hospitals, issued a joint consensus statement to cooperatively improve the PA process. [7]

Since issuing the joint consensus statement, a recent survey found that health insurance providers have increasingly waived or reduced 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.[8]

Furthermore, 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 ePA on improving the prior authorization process.[9] An analysis of AHIP's Fast Path initiative showed:

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[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.
[8] *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.
[9] *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. ,

- 71% of providers who used the technology for most or all of their patients reported that patients received care faster after providers implemented ePA.
- 60% of experienced providers said ePA 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.

Application Programming Interfaces

Health insurance providers support interoperable exchange through APIs

Recently, the Centers for Medicare & Medicaid Services (CMS) released the Advancing Interoperability and Improving Prior Authorization Processes (Interoperability Rules) final rule which requires health plans in federal programs to build and maintain four new APIs: 1) Prior Authorization API, 2) Patient Access API, 3) Provider Access API, and 4) Payer-to-Payer API. These APIs will allow data – including data regarding prior authorizations – to be shared between parties more seamlessly.

During the rulemaking process for the Interoperability Rules, AHIP submitted comments recognizing the important role of payers in these efforts. AHIP and its members wholeheartedly support the underlying goal of moving toward a health care system in which data flow seamlessly among appropriate stakeholders to the benefit of Americans. We also support the specific objectives of achieving interoperable exchange through APIs between payers and patients, payers and providers, and payers with other payers. Furthermore, we support implementing technologies that will permit physicians to look up payer coverage and documentation requirements as well as conduct electronic prior authorization requests and responses.

Now that the Interoperability Rules are final, we have concerns that states may attempt to implement requirements that diverge from them. APIs are incredibly complicated systems to build. In order to achieve true interoperability, consistency in requirements across health care markets (including state requirements) is necessary. Should Minnesota continue to move forward with API requirements we suggest the following:

- Align the state's API implementation requirements with CMS' January 1, 2027, compliance deadline.

- Align to the required PA API functionality with 42 CFR 156.223(b). This rule requires a PA API to:
    - be populated with the payer's list of covered items and services (excluding drugs) that require prior authorization;
    - identify all documentation required for approval of any items or services that require prior authorization;
    - support a HIPAA-compliant prior authorization request and response; and
    - communicate whether the payer approves the prior authorization request (and the date or circumstance under which the authorization ends), denies the prior authorization request (with a specific reason), or requests more information.
- Exclude prescription drugs.

Gold Carding

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. Section 8 of HF 3578 requires health insurers to establish gold carding programs for health care providers or groups of providers with an authorization rate in the 70th percentile over the most recent 12-month period. This is the lowest percentile exemption proposal that we have seen and are substantially concerned about its potential impact on patient safety.

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 – as previously mentioned, health insurance carriers report that up to 30% of PA requests they receive from clinicians are for unnecessary care that is not supported by medical evidence.[10] This in turn will significantly limit a carrier'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

[10] *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.

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.***[11] ***Just one health plan estimates that the gold carding mandate will cost consumers $500 million a year to end prior authorizations – a figure that is estimated for just its members.***[12]

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.[13] 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.[14] Another Milliman study, specific to Massachusetts, predicts that elimination of PA will increase premiums from $51.19 - $130.28 PMPM. One key factor for these huge increases is due to the elimination of the Sentinel Effect on providers.[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.

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[11] *Veto Letter Request to Governor Abbot on HB 3459.* Texas Association of Health Plans. June 3, 2021.
[12] *Id.*
[13] *Id.*
[14] 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.
[15] Busch, Fritz S. and Peter Fielek. *Potential Impacts on Costs and Premiums Related to the Elimination of Prior Authorization Requirements in Massachusetts*. Milliman Report. November 29, 2023. https://www.milliman.com/-/media/milliman/pdfs/2023-articles/11-29-23_mahp-prior-authorization-impact.ashx

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.
- 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. Additionally, health insurance providers need flexibility in operationalizing these programs to keep up to date with medical and safety innovations.

Sincerely,

Patrick Lobejko
Midwest Regional Director of Government Relations
AHIP

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.

[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.