Prior Authorization & Other Federal Updates

Presentation to NAIC Consumer Liaison Committee

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Prior Authorization

NAIC 2024 Spring National Meeting

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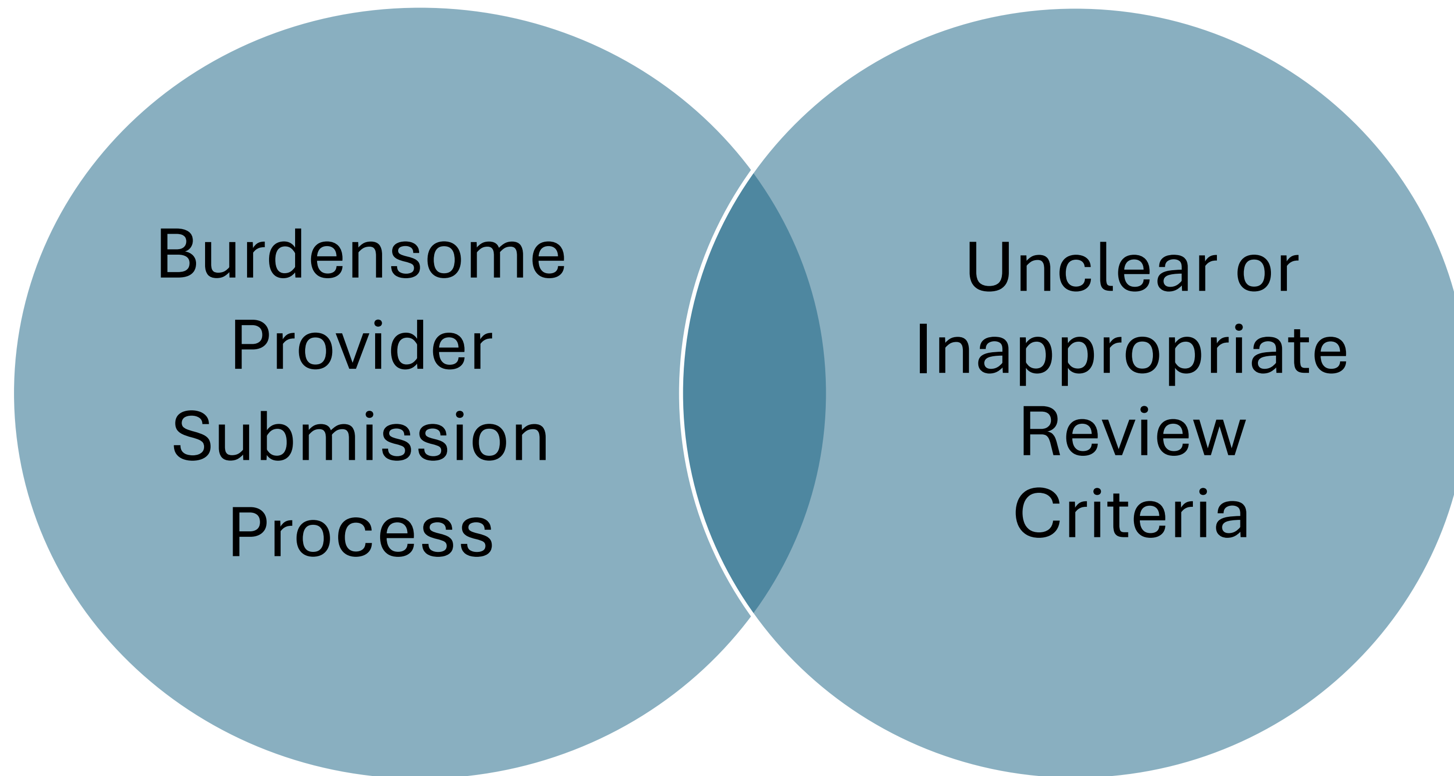
Fundamental Problems



Harms to Consumers

- Delays lead to serious harm – 25% hospitalized, 19% life-threatening event, 9% disability, permanent body damage or death[1]
- Questionable denials
  - When generally accepted criteria are not used
  - Proprietary criteria that lack transparency
  - Reviewers who are not clinically qualified
- Increased provider expenses that translate to higher costs
- Difficulty of appealing denials
- Disproportionate harm to underrepresented & underserved

[1] 2022 AMA Prior Authorization Physician Survey, December 2022

CMS Interoperability & Prior Authorization Rule
Process

- Requires electronic data exchange tools, 2027
  - Medicare Advantage, Federally-Facilitated Exchange QHPs
  - All Medicaid & CHIP plans
- Tools convey if PA required, requirements, status & reasons if denied, 2027
- Initial PA decisions: expedited 72 hours; others 7 calendar days, except 15 days for QHPs, 2026
- Denials must be reviewed by qualified clinicians
- Payers must post annual PA statistics, 2026
- Creates financial incentive for providers to use tools, 2027

CMS Interoperability & Prior Authorization Rule

Criteria

- Requirements only for Medicare Advantage plans
  - Consistent with Medicare statutes,
  - Follows local & national coverage determinations
- Some improvement in transparency
  - Specifying information needed for specific PA decisions
  - Reasons for denial

Shortcomings of the CMS Rule

- Excludes Rx prior authorization, even drugs covered under medical benefits
- Review process
  - Proprietary criteria permitted with no transparency
  - No decision timeline mandates for FFE QHPs
  - Absence of “gold carding”
- Inconsistent criteria across plans – confusing providers & patients
- State-based QHPs, insured commercial plans, ERISA plans excluded
- Annual reporting of PA statistics too aggregated
- Compliance – federal vs. state enforcement not well defined.

Steps States Should Take

- Make state & CMS regulations as consistent as possible
  - PA decision timelines
  - Transparency rules
  - Reviewer qualifications
  - Data reporting
- Collect data to identify outlier plans
  - PA turnaround times & approval rates, *by category of service*
  - Reversal rates of adverse determinations
- Establish state role enforcing compliance with CMS rules

Other Steps States Should Take
(if not already in place)

- Adopt elements of CMS rule
  - Public reporting of PA statistics – pct. initial approvals, pct. denials overturned
  - PA process transparency – standards, data requirements, reasons for denial
  - Clinically recognized standards – independent, peer-reviewed studies, professional society or government guidelines, with no exceptions for proprietary criteria
  - PA decision timelines – expedited 24 hrs, other 72 hrs
- Include Rx drugs – use NCPDP Script[1]
- Add gold carding – providers with high approval rates

[1] National Council for Prescription Drug Programs exchange tool endorsed by Office of the National Coordinator for Health Information Technology

Steps NAIC Can Take

- Maintain inventory of state PA regulations
- Have NIPR compare outcomes under different state regulations
  - Decision timelines
  - Clinical standards
  - Gold carding
  - Appeal processes & timelines
- Collaborate to promote consistency of requirements across states – e.g., coding of procedures & education of providers

Other Federal Updates

NAIC 2024 Spring National Meeting

Caitlin Westerson

Director of State External Affairs & Partnerships, United States of Care

Association Health Plans (AHPs) Proposed Rule

- **Background:** regulations were put in place in 2018 to allow some AHPs to be classified as large group coverage not subject to ACA consumer protections; these regulations were halted by a 2019 ruling
- **What's new:** the proposed rule would fully rescind the 2018 rule and return to pre-2018 guidance that included a more comprehensive review process
- **Status:** comments were due February 20, 2024
- **Timeline:** final rule could come in April as per the regulatory agenda (subject to change)

Short-Term Limited-Duration Insurance (STLDI) Proposed Rule

- **Background:** in 2018, rules governing STLDI plans were expanding to allow them to last up to one year and be renewed for up to three years
- **What's new:** the proposed rule would limit these plans to three months and only allow them to be renewed for one month beyond that, and includes regulations to excepted benefit plans. *This rule has implications for the ongoing deliberations on model regulation 171*.
- **Status:** comments were due September 11, 2023
- **Timeline:** currently at OMB; final rule could come in April as per the regulatory agenda (subject to change)

Notice of Benefit and Payment Parameters (NBPP) proposed rule

- **Background:** the NBPP is an annual rule that outlines the regulations for plans offered on the ACA marketplaces
- **What's new:** this year's proposed rule allowed states to add required benefits without triggering EHB cost defrayal requirements and removed the prohibition on including adult dental benefits as EHB. It also improved minimum national standards for state-based marketplaces and made changes to improve consumer enrollment processes.
- **Status:** comments were due January 8, 2024
- **Timeline:** currently at OMB; in prior years, final rules have typically been released in mid- to late-April (subject to change)

Braidwood v. Becerra (Preventive Services)

- **Background:** Last year, a District Court determined that part of the ACA's no-cost preventive mandate was unconstitutional.
- **What's new:** The District Court's ruling was stayed (or paused) by the Fifth Circuit as it took up the case; the Fifth Circuit could affirm or reverse the lower ruling or expand it to include more or all preventive services subject to the no-cost mandate
- **Status:** Oral arguments were heard on March 4th before the Fifth Circuit Court of Appeals
- **Timeline:** A decision is expected later in 2024 but exact timing is unpredictable; regardless, the losing party is expected to appeal any decision to the Supreme Court for consideration. States are also taking action to codify ACA preventive services requirements into law

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