Prior Authorization Reform Act – HB 711 (Harris) and SB 177 (Holmes): Comments & Summary of Proposed Revisions

On behalf of ILHIC, IAMHP, PCMA, AHIP and our members who represent the commercial and Medicaid health plans that rely on crucial services provided by our partner utilization review organizations and pharmacy benefit managers, we appreciate the opportunity to weigh in on the proposed Prior Authorization Reform Act.

Our health plans recognize the importance of the provider-patient relationship in the delivery of health care services, but ensuring that consumers have access to safe, effective, and affordable care is also an important tenet to the health care delivery system. Prior authorization is a key utilization management tool that is designed to achieve those goals, but the industry does recognize there is an opportunity to streamline and improve prior authorization through a balanced approach to refining this program.

In a recent industry survey conducted by America's Health Insurance Plans, insurers noted that 86% of prior authorization denials are the result of the provider failing to provide complete clinical information necessary to support the initial authorization request, with a majority of those responding indicating that the delay and/or denial of a request could be drastically reduced with the implementation of electronic prior authorization. This bill, however, is silent on automation of the prior authorization process to help address current inefficiencies.

While we appreciate that both HB 711 and SB 177 incorporated some of the feedback ILHIC submitted on HB 5510 in the 101st General Assembly, there are still provisions that raise significant concerns, including:

- Publishing detailed statistics regarding the approval or denial of prior authorizations that fail to accurately capture the complete prior authorization process;
- Applying turn-around-times for non-urgent and urgent health care services and treatments that are more aggressive than current national accreditation standards;
- Applying stringent and untenable requirements on utilization review organizations with respect to conducting reviews of requests for prior authorization and appeals; and
- Codifying approval requirements that put patient safety at risk.

Less than 24% of health care services and treatments are subject to prior authorization, with the most common treatments subject to prior authorization as follows: 1) specialty drugs; 2) high-tech imaging; 3) genetic testing; 4) durable medical equipment; and 5) high cost brand-name drugs. Treatments and services subject to prior authorization represent those areas of medicine that present the greatest opportunity to produce strong patient outcomes, but also pose the greatest risk for patient safety and unnecessary spending.

Illinois also has laws in place addressing prior authorization and utilization management activities that the industry has negotiated exhaustively with patient and provider advocate groups over the years, including, but not limited to:

- Mandatory time frames by which a health insurer must respond to an urgent and non-urgent request for prior authorization of a prescription drug;
- Medical exceptions requirements and restrictions on step therapy requirements that allow a consumer to remain on a specific treatment if the patient is stable;
- Prohibition on prior authorization on FDA-approved prescription medications for the treatment of substance use disorders;
- Prohibition on prior authorization on the initiation of treatment at a substance use disorder treatment provider or facility; and
- Required use of a standard prior authorization form for prescription drugs (beginning July 1, 2021).

It should also be noted that the proposed prior authorization reforms will only apply to individual and small group plans that are fully-insured and will have no impact on the majority of those Illinoisans who are covered by an ERISA plan. Additionally, the provisions explicitly exempt the state employee group health insurance plan, which means that state employees will see no impact and the state will also bear no additional cost of complying with the requirements of this Act (beyond the requirements set forth on the Medicaid program).

A recent cost impact study by Visante estimated that the total cost of further restrictions on prior authorizations specific to just prescription drug spending alone, would result in an increase of $78 million to these fully-insured employers, individuals and their families in the state over the next ten years.

The following summarizes the comments and suggested changes to the provisions set forth in HB 711/SB 177 that have been compiled based on input from ILHIC and IAMHP members. The proposed legislation creates a standard approach to prior authorization for medical treatments, as well as pharmacy benefits, which at times, differ. Furthermore, there are areas of existing law, most notably the Managed Care and Patient Rights Act, that conflict with provisions set forth in the legislation that we have noted in our comments below and the attached proposed revisions.

Finally, the inclusion of Medicaid Health Plans will also require separation of provisions at times to acknowledge different standards due to the unique contractual relationship these plans have with the State that the commercial health insurance plans do not have.

Section 15 – Definitions

Our organizations believe it is important to reinforce the primary focus of prior authorization programs, which is to improve quality of care and promote evidence-based care, and we have proposed adding language to the current definition of "medically necessary" to underscore that point.

Section 20 – Disclosure and review of prior authorization requirements

The provisions proposed in subsection (e) suggest that prior authorizations could not be based solely on the basis of a number of factors, including where evidence-based standards conflict. Evidence-based standards, however, do conflict and this subsection seems to suggest that procedures and treatments that are otherwise considered experimental or investigational would no longer be grounds for a the denial of a prior authorization even if the clincial evidence submitted for the patient supports that denial due to health outcomes and safety concerns.

Furthermore, subsection (e)(4) will prohibit a utilization review organization from denying a prior authorization simply on the basis that the treating provider has recommended the treatment for condition that the treatment has not yet been fully vetted by the medical community. Our organizations have deep concerns about removing checks and balances on the practice of recommending a specific treatment for "off-label" use.

While we support notification requirements that inform both enrollees and their treating providers of any changes to prior authorization, we suggested that the time period in which health insurers have to notify enrollees, contracted health care professionals, and health care providers of a new prior authorization requirements or restrictions be changed to no less than 30 days instead of 60 under subsection (g). Market research has shown that most enrollees and providers are more responsive to notifications issued within the shorter time frame.

Insurers currently publicly post their medical policies, which includes clinical information on which the policy was developed. Insurer criteria for prior authorization is proprietary, but all contracted providers have access to precertification/prior authorization lists, as well as updates to any of those requirements (with notifications issued prior to implementation of those updates). Furthermore, enrollees should be able to access information related to prior

authorization requirements through their member portal based on their beneft plan and coverage policy.

The provisions set forth in subsection (h), however, impose burdensome requirements that are not useful to the consumer nor do they advance improvements or efficiencies in prior authorization programs. The statistical reporting approach proposed requires plans to use a simplified denial/approval reporting structure that does not accurately portray the full scope of the prior authorization process. As noted previously, the most common reason for delays in finalizing prior authorization requests is due to a lack of critical clinical data from the order health care professional or provider, which can result in an overestimation of "inappropriateness."

Conversely, some of the most important care quality gains occur in higher cost, lower volume services, such as oncology treatments where a change in care occurs with the ordering health care professional's contract service agreement during the prior authorization process itself, which is recorded as an approval, but this approval will otherwise be invisible in the reporting outlined in this subsection.

Furthermore, under Section 85 of the Managed Care and Patient Rights Act, utilization review programs are required to disclose some statistics to the Department of Insurance upon registration, including the number of lives for which the utilization review is conducted by the program, the number of covered lives for which utilization was conducted during the previous calendar year, the grievance process, and hours of operation.

Section 25 – Nonurgent Prior Authorization

As noted in the comments of the proposed bill, the turn-around-times for non-urgent prior authorization requirements, while aligned with those required for prescription drugs, do not align with current URAC standards that require a 15-day standard for review of all non-urgent requests for medical procedures and treatments for commercial plans and an 8-day review for Medicaid for outpatient services. Given the Medicaid health plan experience we recommend differentiating timeframes for inpatient and outpatient.

These time frames also impact providers who may need additional time to submit clinical data necessary to approve the prior authorization, otherwise, they run the risk of an increased number of denials as a result. Specifically, the tightened timeframe for the Medicaid health plans has caused provider abrasion especially for smaller and safety net providers.

Section 30 - Urgent Prior Authorization

Our organization's proposed revisions follow comments outlined above for Section 25. Additionally, the requirement that utilization review programs maintain access to a hotline staffed 24/7 is unnecessary and invites costs and inefficiencies into the system that will be borne by small employers and individuals and families covered by a fully-insured plan, particularly in light of the fact that prior authorization is applied to a small subset of health care services and an even smaller set of urgent prior authorization requests.

The majority of prior authorizations are non-urgent and scheduled in advance. Prior authorizations are not typically conducted in an emergency situation and very rarely, if ever, in an ER. Additionally, Medicaid health plans have noted that the volume of after hour requests for prior authorizations is low and therefore, this requirement simply invites more waste into the system.

If a health care professional believes an urgent medical service is needed, then nothing prevents that treating provider from proceeding with treatment. In these situations, providers would submit a post-service authorization for review by the health plan.

Section 35 – Emergency Services

This section, as proposed, conflicts with Section 70 of the Managed Care and Patient Rights Act, which requires the health care provider to make at least two good faith efforts to contact the enrollee's health plan for prior authorization of post-stabilization medical services and neither the plan nor the designated provider were accessible OR the authorization was not denied within 60 minutes of the request. We recommend this section be updated to align with current requirements or Section 70 of MCPRA is amended directly.

Section 40 – Adverse Determination – Personnel Qualifications

The current provisions limit personnel responsible for an adverse determination to physicians only, which completely ignores accreditation standards that allow for a variety of health care professionals practicing in the same or similar specialty as the treating health care professional or have clinical experience with the service or treatment that is the subject of the prior authorization to make determinations about the prior authorization request. Furthermore, these requirements may be inconsistent with the national accreditation standards that are important for a UR firm to register in Illinois.

Section 45 – Consultation Prior to Adverse Determination

The proposed language is problematic as it could pose challenges for utilization review organizations to meet the turn-around-times proposed. For example, if a health care professional or provider submits an urgent request near close-of-business on a Friday that is incomplete in terms of the clinical data required, the utilization review organization would have no opportunity to request a review if the requesting provider's offices are unavailable during the weekend. While the utilization review organization would have the opportunity to do so on Monday during regular business hours, the provisions otherwise proposed in this legislation would mean the utilization review organization is out of compliance and could be subject to significant financial penalties.

Peer to peer reviews are allowed and performed on a regular basis; however, they must be done so at the request of the enrollee's health care professional or provider.

Section 50 – Appeals – Health Care Professional Qualifications

As with the comments and proposed revisions to Section 40, the restrictions on qualifications are much more stringent than those required of URAC and NCQA for first-level appeals. Additionally, the provision requiring reviewing physicians to be independent of the utilization review organization is untenable and could threaten the utilization review organization's ability to meet national accreditation standards necessary for these entities to register in Illinois.

Section 55 – Limitations on Prior Authorization

Illinois already has several laws in place addressing these provisions with respect to prescription drugs. P.A. 99-0761 requires insurers to grant a step therapy medical exceptions request under certain circumstances and the step therapy exception remains for 12 months or upon renewal of the plan. P.A. 100-1024 already removes prior authorization and step therapy requirements on medications for substance use disorders other than those required per ASAM criteria. The provisions set forth in this Section are duplicative, but also conflicting and we propose striking this Section altogether.

Section 60 – Denial

While we appreciate the proponents incorporating our suggested changes to HB 5510 in the 101st General Assembly with respect to the definitions of "authorization" and "prior authorization," we believe the focus of the provisions in this Section should be on the circumstances by which a prior authorization cannot be revoked based on the terms of coverage (and not a guarantee of payment) while reinforcing insurer obligations to ensure timely response and compliance with the Act.

Section 65 – Length of Prior Authorization

Health plans cannot honor a prior authorization request that extends longer than a plan year (12 months). Additionally, the provisions as introduced apply to all prior authorization regardless of medical procedure (including imaging), which does not account for the fact that a patient's clinical needs can change significantly over a year.

The proposed changes reflect current prescription drug medical exception requests (per Section 45.1 of the Managed Care and Patient Rights Act) that allow for an exception request to remain in place for the less of 12 months or upon renewal of the enrollee's plan. The proposed revisions to this Section also incorporate patient safety concerns with those individuals who may be on a controlled substance and to ensure that changes attributed to a drug recall for safety reasons are not subject to this Section. For those enrollees who do not have or qualify for a medical exception request, the prior authorization may be maintained along these time frames as long as the provider responds to requests for medical necessity.

Section 70 – Length of Prior Authorization – Chronic Conditions

Health plans need to maintain the ability to perform concurrent reviews and determine that treatment plans are being followed (as with PT for example). Furthermore, some conditions

and treatments do not require ongoing authorization of coverage beyond 12 months and the language must allow for review of medical necessity, as well as acknowledging that once the enrollee has completed the course of treatment, then there is no longer a need for the authorized health care service.

Section 75 – Continuity of Care

Health plans support honoring a prior authorization request for the first 60 days of coverage, which allows time for the new health plan to re-establish prior authorization, if needed.

Section 80 – Compliance – Automatic Prior Authorization Approval

Section 90 regarding enforcement of the provisions of the Act is adequate to ensure that the Department of Insurance has the regulatory authority to oversee health plan and utilization review program compliance with the provisions of the Act. Furthermore, Section 85 of the Managed Care and Patient Rights Act also outlines utilization review registration and compliance requirements, including remedies for non-compliance that do not otherwise negate basic functions of utilization management programs.