Prior Authorization & the Impact of Utilization Management Practices

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Cancer Support Community

Cancer Support Community

Largest professionally led nonprofit network of cancer support worldwide

Mission to uplift and strengthen people impacted by cancer by providing support, fostering compassionate communities, and breaking down barriers to care.

CSC Website

Cancer Policy Institute – Advocates to make patient voices heard in decision making

Institute for Excellence in Psychosocial Care – Provides direct services & programs

Research & Training Institute – Cutting-edge psychosocial, behavioral, and survivorship research

Cancer Support Community

CANCER SUPPORT COMMUNITY
COMMUNITY IS STRONGER THAN CANCER

Getting involved with CSC

Join our grassroots network

- Learn about key issues that are important to patients with cancer and their loved ones
- Make your voice heard at the local and national level to policymakers

Participate in research

- Participate in surveys, focus groups, and patient summits to help us better understand the cancer experience
- Help us use insights gained from patients and caregivers to inform policies, develop educational programs, and provide vital support for all people impacted by cancer

Call our helpline or visit a local CSC or Gilda's Club location!

- Cancer Support Community of Indiana: https://cancersupportindy.org/
- Helpline for free personalized navigation: 888-793-9355

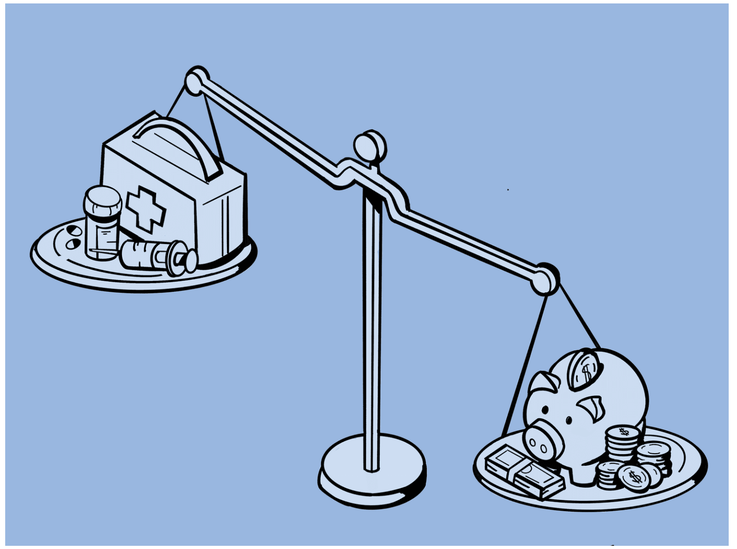
The Issue of Health Care Access in the US

The problem: uninsured → underinsured

- 90% of Americans have some type of insurance, whether coverage provides access to care and treatment is not as clear

High out-of-pocket costs lead to delays or abandonment of treatment

- Average OOP costs/patient ~$3000/month



Utilization Management & Financial Toxicity

~50% of cancer patients experience financial toxicity

Effects of financial toxicity:

- Direct association with stress, anxiety, and social function
- Makes patients 3-5x more likely to postpone care → worsened outcomes
- Increased mortality risk for survivors

Leads to **medical debt,** which disproportionately affects certain groups

- More prevalent for those aged 64+ and in Black Americans

Utilization management practices can exacerbate an already serious issue for many cancer patients

Overview of Prior Authorization

Prior Authorization (PA) is a utilization management technique that requires physicians and other health care providers to obtain advanced approval before a certain service or medication is delivered to a patient to qualify for payment coverage

- Tactic used by insurance companies to control costs
- Allows health insurer – not patient's healthcare team – to ultimately decide whether the prescribed treatment/service is medically necessary

Can lead to serious negative impacts on patient care and workforce productivity

Worst case scenario, can lead to a rejection of prescribed medication or service

CSC Prior Authorization Patient Survey Results

A 2016 CSC report that surveyed ~800 patients about prior authorization found that nearly half of patients reported they were told that the treatment prescribed to them would require prior authorization.

Effects of prior authorization found in the study:

- **Delays:** >26% of people surveyed experienced significant delays in starting physician-recommended treatment
- **Treatment Changes or Abandonment:** >17% of patients surveyed changed their treatment decision due to PA requirements
- **Unexpected Out-of-Pocket Costs:** ~25% of respondents reported unexpected OOP costs due to PA requirements for physician-recommended diagnostic tests/treatments

*According to a physician survey by the AMA in 2023, 24% of providers reported that PA resulted in serious adverse events for their patients

Impact on Providers

UM practices (prior authorization and step therapy) also greatly increase administrative burdens for providers

2023 AMA survey found that 87% of physicians reported PA requirements led to greater use of healthcare resources → unnecessary waste (instead of cost savings)

AMA data also shows that for **every hour of face-to-face time with patients, physicians spend nearly 2 hours on administrative tasks/day**

- 95% report prior authorization somewhat or significantly increases physician burnout and worsened physician-patient relationships

CMS Interoperability & Prior Authorization Final Rule

Establishes requirements to improve prior authorization processes through technology to enhance communication between patients, physicians, and payers

What does the rule aim to do?

- Advance interoperability and improve prior authorization processes
- Increase patient, provider, and payer access to patient health data
- Reduce administrative burdens
- Improve timely access to care

Does NOT address improvement to the PA processes for <u>prescription drugs</u>

Resources to learn more about PA Final Rule

CMS Fact Sheet on Final Rule: https://www.cms.gov/newsroom/fact-sheets/cms-interoperability-and-prior-authorization-final-rule-cms-0057-f

CMS Webpage on Final Rule: https://www.cms.gov/priorities/key-initiatives/burden-reduction/interoperability/policies-and-regulations/cms-interoperability-and-prior-authorization-final-rule-cms-0057-f

Improving Seniors' Timely Access to Care Act (HR 3174)

Codifies many aspects of the Final Rule into law

Establishes several requirements and standards relating to prior authorization processes under Medicare Advantage plans, such as:

1. Establish an electronic prior authorization program that meets specified standards (real-time decisions for routinely approved services)
2. Annually publish specified prior authorization information (percentage of requests approved and average response times)
3. Meet other standards as set by CMS, relating to the quality and timeliness of prior authorization determinations

Does NOT address improvement to the PA processes for <u>prescription drugs</u>

Indiana State Laws: Prior Authorization

Current Indiana law requires that prior authorizations be completed within a 48-hour limit for urgent care and a five-business day limit for other requests

Introduced legislation:

House Bill 1091:

- Starting in 2026, requires health plans to allow health professionals, who have >85% PA approval rate to receive a one-year exemption from the plans PA requirements

Senate Bill 3:

- A utilization review entity may only impose PA requirements on <1% of providers & specialty services each year and provides exceptions with providers has >80% PA success rate
- Sets boundaries on types of services utilization review entities can place PA requirements on
- Requires denied PA requests to be reviewed by a physician

Senate Bill 237

- Establish a standard by which to determine whether a health care service is “medically necessary”
- Requires health plans to employ a medical director to review PA policies
- Restricts scope of PA requirements (rehabilitation/therapy services)

Step Therapy Overview

Step therapy is a tool used by health plans to control spending on a patient's medications

Forces patients into a trial-and-error approach to treatments that may be less effective, chosen primarily for their lower cost

Burdens caused by step therapy:

- Treatment delays → increased side effects, increased need for emergency care, worsened outcomes
- Huge burdens placed on physicians and their practices → burnout
- Time detracted from patient-centered care

CSC's Step Therapy Claims Data Analysis

Examined whether step therapy achieves cost savings when you consider the burden imposed on patients and the system

Phase 1: Identified **5 different oncology drugs** for analysis

- Chronic lymphocytic lymphoma, non-small cell lung cancer, renal cell carcinoma, ovarian cancer, and metastatic castration-resistant prostate cancer

Phase 2: Analyzed **44,000+ patients'** claims and pharmacy data over 5 years (2018-2022)

Results found that prior authorization and step therapy practices only reduce healthcare costs for a small fraction of patients

Indiana Step Therapy Policy Landscape

Current Indiana law requires an override exception request be granted if the patient's health care provider demonstrates that the:

- Drug is contraindicated or likely to cause adverse reaction
- Drug is expected to be ineffective
- Patient has tried and failed the proposed drug
- Drug is not in the best interest of the patient

Insurer must approve, deny, or request supplementation for the override request within 3 business days (1 business day for urgent circumstances)

See steptherapy.com for more info on state laws

Federal Policy Recommendations

Pass the *Safe Step Act* (H.R. 2630 / S. 652)!

- Based on 36 state laws
- Ensures group health plans offer a reasonable exceptions process to step therapy
- Required group health plans to respond to an exception request within 72 hours (24 hours for severe cases)

<u>The *Safe Step Act* will help patients by:</u>

- Establishing readily available, reasonable processes for providers & patients to seek exceptions for step therapy
- Increasing timely access to lifesaving treatment
- Reducing administrative costs and burdens to the health care system

As always, listen to patients!

Importance of Patient-Centeredness

Strong need to ensure that patient and caregiver experiences & perspectives are included in policymaking

When people with cancer have more control over the best treatment options for them, they feel stronger and more hopeful.

Share your story with advocacy organizations, advocate for policy change with your Members of Congress!

CSC's Principles for Patient-Centered Engagement

Thank you!

For more information, please reach out at
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