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## **The Health Wonk Shop: Prior Authorization in Health Insurance: A Needed Tool to Contain Costs or an Excessive Barrier to Needed Care?**

**Larry Levitt:**

Hello. I'm Larry Levitt from KFF. Welcome to the latest episode of The Health Wonk Shop. About once a month we delve into timely and complex health policy topics with experts from a variety of perspectives. Today we're looking at prior authorization in health insurance, or to the cool kids, prior auth. Since authorization is a really long word. Talk to any patient or healthcare provider and you're sure to hear frustrations about requests for care or drugs getting denied by insurers, or the hassle involved in getting care approved. You talk to any insurance medical officer and you'll hear about the amount of care provided that is inappropriate or not grounded in clinical evidence. The fights of prior auth are reminiscent of the backlash against HMOs in the 1990s, and like then, policymakers are starting to get involved with regulations and oversight. And, as with so many things these days, AI may solve some of the problems with prior auth, but also create new ones.

We're joined today by a smart panel of experts from a diversity of experiences to explore how prior auth works in practice and what the implications are policies to regulate it. Troy Brennan is an adjunct professor at the Chan School of Public Health at Harvard, and former chief medical officer at CVS and Aetna. Fumiko Chino is a radiation oncologist at Memorial Sloan Kettering Cancer Center. Anna Howard is a principal for policy development at the American Cancer Society Action Network. And Kaye Pestaina is a vice president at KFF and director of our program on Patient and Consumer Protection. If you have questions, submit them at any time through the Q&A button in Zoom and we'll get to as many of them as we can. Also note that this session is being recorded and an archive version should be available later today. Troy, let me start with you. We've all heard the complaints that I talked about about prior auth from patients and providers. From an insurer perspective, I mean, step back, what is the goal of prior authorization and how effective would you say it's been at achieving that goal? Troy, you're muted.

**Troyen Brennan:**

When you know that would happen. So, the goal is to reduce the amount of ineffective care and the estimates about how much ineffective care there is in the United States healthcare system range between about 15 and 30%. So, there's a big target there. And you said it right, Larry, from the point of view of the practicing doc, this is just a source of great frustration. On the point of view

of the insurance company, especially the chief medical officer office, there's just a lot of unnecessary stuff that's happening out there. It doesn't fit with what you consider to be reasonable practice guidelines. So, from the insurer's point of view, it's pretty straightforward. You identify a place where you think there's a lot of over utilization. You design a program that's based on branching chain logic. I'll give you an example. Bariatric surgery used to be a big one. Does the patient have A BMI that's above 30? And, have they tried diet for six months? Answer of both those things are yes, then the surgery can be approved.

And from the insurer's point of view, if you start to get a lot of approvals and you've got this prior authorization out there, then it's simply not cost-effective. So from the insurer's point of view, there's just basically a return on investment, how many unnecessary procedures are being taken out as opposed to what's the cost associated with putting the program in place. Now, the place where the insurer doesn't get involved and probably is inappropriate, is that there are costs on the provider side and that doesn't go into the return on investment from the point of view of the insurer.

I'll finish by saying there aren't great estimates about these published estimates about how much savings there are, but the average insurer would probably see something like 5 to 7% savings from a strong utilization management program, in terms of overall utilization. So it is worth a lot to our clients and it's the one thing that clients up and down the line, whether you're carrying the risk yourself as the insurer in a fully insured situation, or you're acting as a third-party administrator for an employer, it's the one thing where the clients really want to make sure you have a strong program.

**Larry Levitt:**

Thanks. So, Fumiko, let me bring you in. I won't ask you if you provide any of this inappropriate care, but maybe we can cut to that later. But from a clinician's perspective, I mean, how does prior auth work in practice? What does it mean for how you care for your patients?

**Fumiko Chino:**

No, thank you so much for that question. I'm a treating radiation oncologist, which means I deal with people with cancer. And cancer biology doesn't wait for bureaucracy. And I think that's really the problem that we face within our clinic for people who have sometimes very fast-growing cancers, is that, I'll be honest, even appropriate prior authorization creates delays to care and that can decrease outcomes and it can affect things like cancer survival. We know that providers are increasingly frustrated, because we're facing increasing barriers to prior authorization and it's causing longer delays. One survey found that over 90% of physicians had some delay related to patient care for the patients right

in front of them. And we know specifically within cancer that those delays can lead to catastrophic outcomes.

And so, it's leading to some amount of wasted effort on our part, because the vast majority of the care that faces prior authorization for my practice gets approved. One study found that it was basically an hour for every incident of prior authorization for just the provider. But that, it's leading to again, moral distress. And when I think about prior authorization as a burden for cancer, it's not just for cancer treatments, it's even for things like pain medication and when you're having to talk on the phone to someone who's having uncontrolled pain and your hands are tied due to prior authorization, it is leading to increased burnout. Ultimately, affecting the patient's in negative ways and the physician workforce.

**Larry Levitt:**

Thanks. Well, we'll come back to a lot of these issues, I'm sure. Anna, let me bring you in. So from a patient perspective, what are some of the challenges in navigating this process, especially for-

**Anna Schwamlein Howard:** Yeah, there are a lot of challenges in navigating this process from a patient perspective. I mean, patients face the most disruption in care and have no power in this process at all. So you're facing situations particularly in cancer care, an individual who may be waiting for prior authorization for their pain medication. And if they have to wait several days, their pain may get too much and they may end up at going to the emergency room, which is a higher cost, not only for the payer, but for the patient as well.

And so, this is something where the individual... Or, you're a pennywise and a pound foolish on prior authorization requests like that. You're also seeing oncologists practices that are spending a lot of resources to hire FTEs to manage prior authorization requests. Well, this is money that could have been spent on direct patient care and helping people to navigate the system. There's also a question of when patient navigation... Or when prior authorization is imposed and delays care from a patient perspective, particularly in cancer care, that individual has had to take time off from work, and figure out childcare, and figure out transportation, and caregiving. And when those delays happen in cancer care, it not only impacts that individual patient, but it also impacts everybody else who's involved in that process.

And so, think of somebody who works on an hourly basis, and is undergoing cancer treatment, and their cancer treatment is supposed to start on a Tuesday, and Monday they got a call saying, "Well, we're still waiting on prior authorization, so we're going to have to push your time back." Well, now the

individual who may have already rearranged their work schedule now has to rearrange their work schedule again, more time off, less income coming into the patient. It's very disruptive. You also see a lot of prior authorization on things like imaging, when cancer imaging can be a, "Let's see if the cancer has progressed." And so, awaiting on imaging to find out whether or not the cancer has progressed, whether you need to switch to a different chemotherapy treatment regimen, what have you. That's a huge psychological burden for the patient to undergo.

**Larry Levitt:**

... Thanks, Anna. I apologize. My computer completely crashed, so I rejoined on my phone. Hopefully, everyone can hear me. Troy, let me come back to you. And you talked about if you see lots of requests for care being approved, then prior auth may not have that return on investment from an insurer's perspective. You might think of this as a sentinel effect, right? I mean, how much of this is the actual denials of prior authorization saving money, and how much of this is sending a signal to clinicians about what the insurer considers medically necessary or not?

**Troyen Brennan:**

Yeah, there is a shadow effect associated with it and reasonable insurers, I know Aetna for the last 20 years we've published basically what the criteria are for what we find to be acceptable care within reasonable guidelines. It divides out a little bit between drugs and procedures, because in procedures you don't need to do randomized controlled trials and you don't have a label that says what the indications are. So drugs are a lot easier in many ways, because the drug is provided with a label that says this is what's indicated. And when you get somebody requesting a drug that's not indicated, then prior authorization will obtain. But, I would say with regard to the statistics and data about it, first of all, on the harm side, there's really not any good studies, and I try to keep track of this fairly closely showing actual harm. There are a lot of surveys from physicians in particular that say that there are tremendous delays, but there's obviously a response bias associated with this.

It's always been fairly heavily regulated. So one place where ERISA plans are actually regulated. So, generally speaking, at least from the federal government's point of view, 7 to 14 days, 7 for expedited, 14 days typical. And for drugs, 24 hours in three days is what the federal government expects. And those deadlines are widely used and people pay attention to them because there are fines associated with the labor department under ERISA and certainly fines under Medicare and STAR scores. They're related to how well you do in terms of making these determinations within limits. The costs of it, they're difficult to calculate. The calculations go from \$27 billion by one group to \$1 billion from another group.

But, recent MBER study suggested that if you take this administrative costs on the provider side and the insurer side, and then look at the cost that's avoided, the return on investment is about 10 to 1. So, with regard to does this seem like a reasonable thing for the insurers to continue to do? It does. But I think they're all facing pushback obviously from legislators, patients, and doctors who are concerned about it. And I think they're probably sharpening up somewhat to retreat back away from utilization management that doesn't have a sharp return on investment and making sure that they are doing just things that they would consider to be non-controversial. And believe me, there's a lot of things as you get requests for that seem non-controversial in terms of being not needed.

**Larry Levitt:**

So, Kaye, let me bring you in. So, I mean, Troy mentioned, Fumiko mentioned the delays, and that's been a particular focus of policymakers. Biden administration recently issued regulations governing prior authorization. Explain what those regulations do and importantly what they don't do.

**Kaye Pestaina:**

Sure. Those new final regulations that CMS issued about a month ago, they seek to improve the prior authorization process really by streamlining, trying to avoid these delays by making the process faster. And these rules, they're supposed to apply new standards across different payers that CMS regulates, applying similar requirements, and this includes a Medicare advantage, Medicaid and ship, both fee for service and managed care plans as well as qualified health plans on the federally facilitated marketplace. All of these payers would have to meet some new standards.

It doesn't apply to state-based marketplaces. It doesn't apply to the employer plans, whether insured or self-insured. It really is talking about prior authorization process for medical items, not prescription drugs. Those were carved out of these rules. And actually, CMS got a lot of comment about that. And, in their final rule, it said that they will consider options for future rulemaking when it comes to prescription drugs. But for now, this is just the medical items. And probably, the biggest part of this rule is about interoperability. It's about improving the efficiency in the processes that exist today through standardized electronic data exchange where these payers have to make specific information available through a prior authorization application programming interface, an API. So that process could be automated. A provider, for instance, would be able to access all the items and services that the plan requires prior auth to be performed. It could access the documentation requirements that they're required to provide, and also query the system as to the status of any prior authorization is approved, denied, what's pending, require additional information.

And, not only is this prior authorization API part of this new rule, it also deals with three other APIs, I won't get into it, where patients can access information and providers can... And also, payers might be able to exchange information to make the process more efficient. But, the remaining standards and the new rules actually apply to three issues, regardless of whether electronic or not. All of these payers will have to shorten timeframes for making decisions on prior auth. With the exception of the qualified health plans on the federal exchange, all the other payers would have to have shortened the timeframes. First, the end of decision would have to be seven calendar days at the most to make a decision expedited at 72 hours. So that's shorter for most of those systems.

It also requires plans to provide the specific reason for any denial of a prior auth to the provider. And all these programs have different rules with respect to notice, but this would seek just to align the rules, so then make sure that for all these programs, providers are getting information about a denial as the reason for the denial so they could take action quickly. And then, last, which is new for I think all of these programs, which would be a requirement for these plans to publicly report certain matrix about prior authorization, including the percentage of denials and approvals for standard versus expedited, the percentage of approved prior auth claims that are approved after an appeal, that type of thing. So, those are the main issues. Here, we're really talking about streamlining the current processes. We're not really talking so much about how the prior author decisions are made. For instance, the clinical criteria, or the method AI, or otherwise. This is really about making the process quicker.

**Larry Levitt:**

Fumiko, how far did these rules go in addressing some of the issues you see with prior auth? Or, what do you think is missing from these regulations?

**Fumiko Chino:**

I mean, I welcome any regulations for prior authorization, because right now, it feels like the Wild, Wild West. Sometimes, where I'll never know when I'll be faced with a prior authorization barrier. I will say that even one day of delay means potentially uncontrolled pain. Or, in my case, I treat gynecological cancers one day, and cervical cancer actually equates to a 1% decreased local control rate. And so, if you have a five-day delay, that's a 5% decreased local control rate, if you have a 15-day delay, et cetera. So, even one day of delay can lead to worse outcomes, but increased transparency 100%, we absolutely need. Because I'll be honest, when I face a prior authorization barrier for someone and I know the mechanism for what they're denying, I will be like, "Okay, we need to pivot immediately, because I've already dealt with them before and I need to get another plan ready together". And so, it actually facilitates me knowing what the next steps are to provide the very best care for the patient.

Transparency, decreased delays, these things can only help improve the process.

**Larry Levitt:**

And Anna, I want to ask you about appeals. I mean, patients do have some rights to appeal here. What are those rights? But what are some of the difficulties patients face in actually-

**Anna Schwamlein Howard:**

Yeah, so patients face a lot of difficulties. One is that we know that most patients don't appeal decisions, if it's just natural behavioral outcomes that individuals, they don't want to file appeals. They don't want to go up against an insurance company that quite frankly does this for a living. And you have a patient that doesn't have the medical knowledge, doesn't understand the system, doesn't understand the process, they're going up against a multinational, multi-billion dollar company, and they just say, "That's it. I'm walking away." And so, a lot of things just don't get appealed. And we know that when things do get appealed, yes, you do see the evidence and I think the transparency argument about, "Let's find out how many things are overturned on appeals and what level of appeals." Because that's also going to highlight maybe a lot of these denials in one particular area may not have been necessary. If you see a high percentage of people who are winning on appeal, that signals that there may be a problem with the criteria that was used on the lower prior authorization review process.

And I just wanted to get back to something that was previously mentioned in terms of the delays that patients face. Particularly, in cancer care, there's a lot of waiting. So if you see something like biomarker testing, for example, you see precision medicine in cancer care, where you have to face prior authorization for the test to determine what the biological markers and genetic markers that are needed for specific chemotherapy. If you have a seven-day delay in approval of the biomarker testing, then you have to wait a week for that. Then you get the test, you have to wait for the results, and then you have to wait another seven days to get approval for the specific type of chemotherapy, depending on the results of the biomarker testing. That's an additional time that patients are waiting to get the right treatment that they need to face their cancer.

So, while we appreciate the fact that the final rule did make clear and set in deadlines, again, a seven-day deadline, and 72 hours for an expedited process, we would like to see those timelines sharpened a bit more to 72 hours for non-expedited, and 24 hours for expedited.

**Larry Levitt:**

... I want to turn to some of the audience questions, and we have a lot of them. So there were a number of questions about gold carting providers. Troy, let me

start with you. Explain what this is. You may be most familiar with what Aetna and CVS have done? What have payers done to gold card providers?

**Troyen Brennan:**

Well, gold carding refers to you've got a group or let's say a radiation oncology group or a group of oncologists, and they typically do not submit for things that the insurance company would consider to be ineffective. They've got a very high rate of approval, you would gold card them, meaning that you would no longer put the prior authorization in place. And, it is something that a lot of people have experimented with and there are a number of the smaller insurance companies do a lot of gold carding. They also relate gold carding to their network contracts.

But, I think, goal carding is something that is probably streaming next to this overall tightening that the new rule does. And, in many ways, I prefer the approach that the new rule is taking. I think, just to go back to the new rule for a second, getting to the specifics in, it's difficult, it's a 700-page rule. But the timeframes as they're being decreased from basically 14 days to 7 days, and the transparency of the [inaudible 00:24:09] I think are important. I don't think that the insurers are concerned about that, because at least in their Medicare advantage thing, I would say, most of the insurers are probably at three and a half days right now anyway.

And so, I think transparency around that and reduction in the timeframe is something that all can find acceptable. The other thing that they could have done better, and if you look through the rule, at least on 50 different occasions, CMS is saying to ONC, "You've got to do your part on the electronic medical record." Because the whole API format is basically aimed at the insurers. And it will help people, it will help people like in Fumiko's practice get the information that they need and not have to get on the phone and things like that. But this whole process could be completely automated today through fire based APIs, where the prior authorization would basically interrogate the electronic medical record and come back with a decision immediately. So there's nobody having to be involved in that, and then a decision made, and then that decision may be appealed or not.

But, I think from the payer's point of view, that's something that they would welcome, because obviously that decreased their costs of undertaking this. But, that part, the ONC part of it, requiring that the EMRs interact with these APIs is not something that's been done now. And I think there probably needs to be more pressure on ONC. And as Kaye said, I would've preferred that they had gone after the drugs. Well, obviously drugs under part D have a much shorter timeframe, but I think it would've been appropriate to include drugs. And the



reason they gave was that they couldn't get to the NDC codes, which seems to me to be not a good reason. The work hasn't been done, but they should have insisted that that work be done so that drugs could be included in this API format as well.

**Larry Levitt:** Fumiko, let me ask you, so we had another question about how much prior auth or utilization management in general varies from one insurer to another? I assume your practice you're dealing with multiple different plans. How much variation is there and how much of a bureaucratic hassle does that create?

**Fumiko Chino:** It's a fairly significant variation. I really don't know who's going to have a prior authorization barrier until I put in my plan. So, what I expect as a treating radiation oncologist at a world-leading cancer center, what I think is probably the best plan for the patient, and then it'll be kicked back to me, "No, no, no, that's not what we want for this patient. This is what should do." And so, at this point, when I actually talk to patients, if I think anything is going to require a prior authorization, I'll warn the patient in advance, so that they don't have this peak of anxiety when they get denial letter in the mail. Often, by the time they get the denial letter, it'll actually already have been approved on appeal, because we're that efficient. But, it helps reduce anxiety, because research has shown that prior authorization leads to a huge spike in anxiety for patients. But I just warn people in advance, because I just never know. There's huge variation.

What we've noticed in radiation oncology, at least though, is that many different insurance plans are all using some of the same utilization middlemen essentially. And so, when I get a barrier from Evercore, I know, "Okay, they will approve this. They will never approve this. So, we need to think of an alternative plan." In a weird way, that's a transparency, right? Which is, at least I know if I'm dealing with Evercore, they're going to say no to this, they'll say yes to this, and I have to figure out how to check the boxes. We'll circle back though to this idea that sometimes the actual utilization management processes are really rooted in either old staging or old technology.

I treat cervical cancer as previously mentioned. And, what I have to put in for, for example, the stage is still going by staging from years ago. So, they've never updated their template for the current staging system. So, I have to still put in that it's node positive stage three, as opposed to the updated staging, which has been years now. And so, the whole process, I think, has some significant flaws. I'd like to see it rebuilt from the ground up.

**Larry Levitt:** So speaking of that, I mean, Troy mentioned this dream of the API interface, and querying the electronic medical record, and having it all be fairly automated. I

have to ask you, do you have a fax machine in your office and do you ever have to resort to that?

**Fumiko Chino:** We fax all the time. It's insane. The technology requiring faxes is so frustrating, and the fact that we still have to fax things seems bananas. I mean, my linear accelerator shoots out electron guns, hits a tungsten plane and shapes radiation to people's body, and yet we're still relying on faxes to get some of these treatments approved. It is bananas.

**Larry Levitt:** Only in healthcare. So, Kaye, we had a question about medical necessity. What care is medically necessary? And Troy mentioned this as well. So, back up a little bit, who defines what is medically necessary and what are the rules governing that?

**Kaye Pestaina:** Well generally, obviously across different programs, but medical necessity, the plan does define it, and there is some transparency. I know in the employer world where I spend a lot of time that criteria, at least the definition of medical necessity should be part of the plan document that a consumer can access. The part that's harder is to know what is the clinical criteria that is the basis of a medical necessity from the patient's perspective and even the provider's perspective, from what I understand. So, that's often a barrier. And that's the plan decision. So, it could differ from plan to plan, but it's not always visible if it does. So, that's the quick 101 on medical necessity. There's no standard definition, but often they are required to be evidence-based and that's what they are. But there isn't a lot of transparency to that.

**Larry Levitt:** Anna, we had a question about what happens when a prior auth request is ultimately denied. What do patients do in those situations typically?

**Anna Schwamlein Howard:** Right. So in that situation, a patient has gone to their doctor and their doctor has said, "This is the treatment that I recommend based on my myriad of years of practicing." And, the insurance company denies that. And so, from a patient perspective, you're stuck with, "Well, wait a minute, my doctor said I needed X treatment because that was the best treatment that's recommended to treat my cancer." For example. "And now, my health insurance company is saying, 'Well, that's not medically necessary.'" So they're left in this, "Of the two, who do I believe? I'm going to believe my doctor over my insurance company." And then, they're left with, "Okay, so now, I have to undergo the second-best option and maybe this other option in treatment doesn't take into account my comorbid conditions. Doesn't take into account the fact that my preference is to minimize side effects, so that I can continue to work and continue to be an active parent or manage other life issues that I need to

undergo. Being able to drive. Minimizing long-term effects from various treatments."

And so, again, the patient is just left in this powerless void, and it's very unsettling. Not to mention the fact that all the while they've been waiting throughout this process to determine coverage of treatments for their disease and condition.

**Larry Levitt:** Right.

**Fumiko Chino:** Can I jump in there really quick?

**Larry Levitt:** Please. Yeah.

**Fumiko Chino:** I wanted to mention just a little bit this horrible double called step therapy, which I think we force our patients to unwillingly participate all the time in. And the best example I have within my own practice is for pain medication. And so, if you have, for example, someone with chronic durable cancer related pain who needs a long acting pain medication, their insurance will specifically deny everything except for... You have to try and fail a bunch of things to get to the medication that may work best for the patient, right?

And so, you have to go through these series of documented, "We tried this. We tried that. Their pain was still uncontrolled." And that frustration of knowing that, "I was stable on this medication over the last year, and yet now I need to disrupt my life to try and fail, to have uncontrolled pain and for it to be documented for me to ultimately approve is so frustrating." Especially when these formulas can change from year to year. And that means you can really have been on an approved therapy before, the new year comes and suddenly you need to try and fail again, which is just really frustrating for our patients, at least to worse quality of life and worse function.

**Larry Levitt:** Troy, let me ask you on this issue of step therapy, how often is that used from a payer's perspective and how effective do you think it is?

**Troyen Brennan:** Well, I think it is used frequently, and mostly on the drug side obviously. And, it's used usually to drive people to a less costly alternative that's proven by the medical literature to be just as effective as the more expensive drug that led to the step in the first place. So, it's the thing that's really increased the amount of use of generic medications, which is literally one of the few success stories in the United States healthcare system in terms of controlling costs, because we use generics 90% of the time now and that's what step therapy is based on. I

would just push back a little bit on the transparency and the decision making around what the medical standard is. Most of the major insurers have public websites today that go through each diagnosis and intervention, and then have the literature that they rely on for their decision making. So, it is fairly straightforward in terms of understanding what the thinking is.

And the difficult cases that I had seen in the past, and obviously, I haven't done this in several years. I retired two years ago. But would be where you had somebody who wanted to use a drug that worked for one tumor but was not known to work for this tumor. But the molecular aspects of this particular tumor were similar to the tumor for which it did work and there was not a randomized control trial, but four case studies in which the drug appeared to have worked. It's that highly articulated situation where you get into a discussion where it's not entirely clear what the standard of care is. Now, I admit that many of the insurers all have different approaches to these things and the standard of care is fuzzy in certain areas. And so, I think it's terrible for the clinicians that they have to end up with a situation where it's approved by one company and not approved by the other. But that is all too typical in the procedure related area where we don't have the benefit of randomized control trials to really tell us which direction we should head.

So, I think that the insurers are... I know most people aren't going to believe this, but they are quite concerned about the fact that they might be obstructing necessary care by taking on utilization management programs. So they do take it on very seriously and they take their responsibilities very seriously in that regard. Step therapy mostly in drugs and actually quite useful and ubiquitous, as most people know. And using an approach of either co-insurance or deductibles to make sure that people have a financial incentive to follow the approach. But, most studies of moving people to generic medications suggest that you improve health, because people tend to take the generic medications because there's no copays associated with them. So, again, something that I think that most people in the insurance business would think was not only reducing the cost of care but also improving the quality, because the adherence levels go up.

**Anna Schwamlein Howard:** So just to circle back on that. Again, in cancer care and in other complex diseases, medication is very specialized and we want to make sure that the individual is getting the right medicine at the right time. And so, cancer patients often are subject to step therapy, which can be very challenging, because particularly if you have a comorbid condition and there's a drug interaction that you're taking and that can cause problems. Patients understand the cost that they have to incur for their care. They're very aware of how much they are spending out of pocket. Generic drugs are on lower formulary tiers and patients

are encouraged to take generic drugs. That's why you see such a high utilization of generic medications.

Step therapy, again, can be problematic for individuals with serious diseases. But step therapy alone is not the reason why we have a 90% adherence on generic medication, it's because individuals go and they see their out-of-pocket costs associated with their prescription drugs and they say, "Hey, is there another option that's medically indicated for me, but one that I can afford?" And, to the extent that they can use generic drugs, absolutely, they're going to be wanting to use generic drugs because they know that it's less expensive for them.

**Larry Levitt:**

We had a series of questions about AI, which I want to get to. But also, who is making these decisions at insurance plans? And Troy, let me come back to you and then Fumiko bring you into this as well. Troy, I mean, what is the process? Who is actually making these decisions on a day-to-day basis?

**Troyen Brennan:**

Well, it's probably easiest to talk about the drugs in the federal programs, the drug criteria 24 and 72 hours as I think the panelists know. And so, the initial determination is made by a pharmacist usually. And, as I said, the easy thing about drugs is that they come with specific indications, like it's this drug is indicated for these diseases. So, if you're getting somebody requesting a drug per a different disease, then that's going to trigger the prior authorization. And then, that's going to go back to the clinician. Usually, these things are going to be clinician-led, at least from the insurer's point of view, as opposed to having the patient get involved with it. And then, there'd be a back and forth. And then usually, another determination is going to be made by a physician who's on the staff of the insurance company.

And then, if there's disagreement there, in most situations, most contractual situations as with employers that are overseen by the ERISA law, the self-insured situation, as well as in Medicaid programs and Medicare Advantage, there's going to be the opportunity for an individual who's not involved. In other words, somebody who is a reasonable expert, who is not employed by the insurance company to come in and give an impartial review. And then, that's going to be basically the final determination. So that's the general process. And, it's one that's, I think, ubiquitous today, especially with regard to the availability of impartial reviews. And, that's where things begin to take a long time, but you're up against those deadlines, and so you have to expedite it. And fortunately, there's lots of companies you can go to that have these impartial reviewers to be able to make these decisions rapidly.

**Larry Levitt:** Fumiko, let me ask you, so who are you typically dealing with at an insurance company? And, are you the one making those contacts, or do you have folks in your office who were doing that on your behalf?

**Fumiko Chino:** It was a radiation oncologist was a truly specialty cancer care. We have this whole team of people doing prior authorization on the daily for hundreds of patients at our cancer center, again, every single day. But I will say that increasingly... And I will say that this is a real gain for prior authorization in terms of wins, is that, if I'm on the phone with a peer-to-peer trying to get a denial approved on secondary review, it is almost always with a radiation oncologist at this point. So someone who's truly a peer, whereas in the past it was a pediatrician, or a family medicine doctor, or someone who honestly doesn't treat cancer. So that's a real gain. And, the amazing thing is that when I'm a radiation oncologist talking to a radiation oncologist, I have not had them deny the care.

And so, that is a real win that increasingly we're seeing subspecialty level approvals, because I truly believe that they want the best for patients, just like I want the best for patients. And we're just trying to figure out a way through this broken system is what I'll call it to get the best care in the best way possible.

**Larry Levitt:** Troy, let me come back to you. We also had a question, and you mentioned at the start, I think bariatric surgery. We had a question about medications to treat obesity in particular. And I know you said you retired a couple of years ago, and the use of these medications has increased dramatically in those couple years. But, are you aware of how insurers are approaching that from a prior auth or utilization review perspective?

**Troyen Brennan:** Well, I mean, again, similar probably to bariatric surgery. And these are the expectations that are set by the experts in weight management with regard to efforts that are not drug related to be able to reduce someone's weight. And then, people failing that, qualifying for the GLP-1 agonists. They've been great drugs for a long time. We were using them in diabetes for years before they became weight control drugs. And, they have great data associated with their efficacy in weight loss. So, randomized controlled trials that demonstrate that they actually really do work.

And so, more than prior authorization there, that's going to be a determination that's made by individual employers or the federal government about whether or not they're going to use drugs. They're going to pay for the use of drugs for weight loss. Today, the federal government really doesn't do that. And there's lots of employers recently, I think, KFF highlighted that the North Carolina state

decided that they weren't going to cover GLP-1's for weight loss going forward, simply because of the cost associated with them. So, it's not so much a utilization management issue, as it is an individual payer that is an individual employer can decide it's going to be a covered benefit. And, as a result of that, the employer simply doesn't pay for it. And if the person wants it, they have to go out of pocket.

**Larry Levitt:** So, as I mentioned, we did have a lot of questions about AI and prior auth. And, we have only limited time left, but I want to spend a couple minutes exploring that, and get each of your views on the promise and the peril of greater use of AI or algorithms in prior auth. And Anna, maybe I'll start with you.

**Anna Schwamlein Howard:** Yeah, absolutely.

**Larry Levitt:** Yeah. Is this going to increase trust with patients or decrease trust?

**Anna Schwamlein Howard:** I think that that's not something that the average patient is contemplating, right? The average patient, when they go in to see their doctor, they're not even thinking about the role of AI in decision-making. They're focusing on getting better. And, "What do I need to do to get better? What changes do I need to make in my life in order to get better?" I think that as we see the use of AI increase, one question we have is, what's the data that's going into these algorithms? What data are these algorithms based on? Are they the most current data? Do these algorithms include old studies that may not reflect the best medical knowledge that we have right now? How often are they being updated? Are they being encouraged to deny care, at least at the first level? Let's get some more information on that. And I think, more transparency regarding the use of AI, and also data on how often first line prior authorization requests using AI are overturned on appeal, that is going to be very helpful as we go forward in this debate.

**Larry Levitt:** And Kaye, let me ask you, what regulatory challenges do you think AI poses in prior auth?

**Kaye Pestaina:** Well, it's just getting behind the black box of what's the process, as Anna just said, "What is the algorithm? And how up-to-date is it?" And, keeping up. The problem with regulation, of course, is keeping up with changes that happen so fast. And at the moment, there is very limited regulation of the AI process. The good part is just now with the scrutiny that we can actually look behind and see how the process works, how AI is being used and non-AI things, but tools that have been used for a long time, how are they being used? So, that's not a bad thing. And, there is scrutiny. Just last week there was a senate hearing on AI,

and healthcare, and issues or claims. And of course, there's been some recent litigation mainly involving Medicare Advantage plans and use of AI. So, just to focus on the issue and the process for the better or worse, I think, is a good thing.

**Larry Levitt:** And Troy, I mean, algorithms are not new here. How promising do you think new technologies are?

**Troyen Brennan:** I mean, a lot of the original utilization management still today is just really basic branching chain logic. It's addition and subtraction, compared to AI. But what AI promises is that interrogation of the medical record, rapid updates with regard to the literature, comprehensive information available in a very short period of time. So at least from the point of view of trying to avoid delay. Look, we talk about cancer, it takes over four weeks to get in to see an oncologist or a radiation oncologist today. And I hate to think that part of that delay is the result of people having to deal with prior authorization.

So any decrease in latency period of getting people treated is an important thing. And I think Anna's right, as long as you've got the transparency and you can understand what these algorithms are doing, then I think it's potentially a very important improvement overall in the process. I wouldn't be afraid of it, ex-anti, but you would want to make sure you've got complete transparency and understand what's going on. Eventually, after the AI does this work, it still goes back to a discussion between Fumiko and another expert radiation oncologist as to whether or not this is the best course of therapy. So, we at least have that as the final place where the decisions are made.

**Larry Levitt:** And Fumiko, I'll give you the last word here, promising, perilous?

**Fumiko Chino:** I welcome our new computer overlords with some caveats of we know that datasets are very flawed and that, for example, marginalized populations are much more likely to have undocumented stage, or they may be missing key elements from their EMR notes that then would lead to barriers and therefore may disproportionately face denials. And then, you've trained a machine based on a dataset that is essentially racist, right? And, I think that's ultimately what we have to fight against when we think about using these large datasets to start driving clinical decision making.

**Larry Levitt:** Well, thanks. I think, that all is a topic for another day. So this was a terrific discussion. I want to thank all of you. Thanks to the audience for terrific questions, for hanging in there with my technical difficulties. And, join us next time on The Health Wonk Shop.



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