

Addressing Commercial Health Plan Challenges to Ensure Fair Coverage for Patients and Providers





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Executive Summary

Hospitals and health systems are committed to ensuring timely patient access to medically necessary health care services. Comprehensive health care coverage is a critical tool to help individuals and patients access and finance their care. This is why hospitals and health systems have long advocated for a robust system for universal coverage rooted in our long-standing public-private model that relies on a strong commercial health insurance market alongside the Medicare and Medicaid programs.

However, while some health insurers provide value through collaboration with providers and their enrollees, many others are increasingly adopting policies and practices that contribute to delays in patient care and place undue burdens on both enrollees and health care providers. Many of these practices also add unnecessary costs to the health care system. In a recent survey of members, the AHA learned that **78% of hospitals and health systems' experience working with commercial insurers is getting worse, not better.**

Patients should be able to rely on their health insurance plan to facilitate covered, medically necessary health care services when they need it without delays or inappropriate denials, and clinicians should be able to focus on caring without burdensome obstacles. This report explores why more oversight is needed to ensure appropriate patient access to care and reduce unnecessary cost and burden.

Report Highlights

Certain commercial insurers that serve the individual and group markets, as well as the Medicare Advantage and Medicaid managed care programs, are erecting unnecessary barriers to care that have a human cost. This includes improper use of utilization management programs, inappropriate denial of medically necessary covered services, overly restrictive medical necessity criteria that are not transparent to patients or providers, unnecessary and unreasonable documentation requirements, and mid-contract changes to patients' coverage.

Some commercial insurer policies and practices appear designed to simply create barriers to appropriate payment. They also contribute to clinician burnout and significantly drive up administrative costs for the health care system. And much of this effort and cost is unnecessary. For example, among some insurers, most appealed prior authorization denials are ultimately overturned. Of course, this appeal process comes with significant cost.

There is mounting evidence that these practices are growing. Government agencies, as well as courts and arbitrators, have continued to uncover concerning findings with respect to certain commercial insurer conduct. It is increasingly clear that some insurers are pursuing a strategy of denying appropriate care to avoid legitimate payment obligations.

In addition to the financial and emotional stress placed on enrollees, inappropriate payment delays and denials for appropriate care have serious implications for the financial stability of health care providers and compound fiscal challenges plaguing our health care system. More than \$6 billion in delayed or potentially unpaid claims over six months old was reported among the 772 surveyed hospitals alone.

Recommendations At-a-Glance

Actions are needed to ensure patients get the care they are entitled to, providers do not face unnecessary burdens, and the health care system is appropriately resourced, including:

- **Standardize prior authorization requirements and processes.** This includes increasing transparency on services that require prior authorization, standardizing the format and process to transmit requests and responses, improving the timeliness of responses, requiring more detailed and complete denial notices, and streamlining appeals processes.
- **Ensure necessary oversight to stop inappropriate prior authorization and payment delays and denials.** This includes improving collection of key performance metrics, applying financial penalties for inappropriate delays and denials, and ensuring adequate provider networks.



Introduction

Most Americans receive their health care coverage through commercial health insurance; yet in recent years, it has become apparent that certain commercial health plan practices restrict patient access to care and increase cost and burden to the health care system. The following report documents the American Hospital Association's (AHA) findings related specifically to prior authorization and payment delays and denials. This work is informed by two large surveys of hospitals, as well as interviews and group discussions with hundreds of hospital and health system leaders. AHA fielded these surveys in 2019 (more than 200 hospitals responding) and again between December 2021 and February 2022 (772 hospitals responding from 47 states).

While some of these findings predate the COVID-19 public health emergency, the more recent data results reinforce that certain insurer practices have remained a persistent problem for health care providers and patients during and after a global public health crisis, and that action is needed to address these issues. **In fact, our most recent survey found that 78% of hospitals and health systems reported that their experience working with commercial insurers is getting worse. Less than 1% said it was getting better.**

The report concludes by offering policymakers solutions to reduce the risk and burden of these programs while still enabling health insurance plans to compete on quality, benefit package design, provider networks and other important aspects of coverage.





Background

Commercial health insurers are the dominant source of health care coverage for most Americans. Most employers, as well as the Medicare and Medicaid programs, rely on commercial health insurers to provide or administer their health benefits. Nearly half of Medicare beneficiaries are enrolled in a private Medicare Advantage (MA) plan, and enrollment in MA plans is growing at a rate of nearly 10% per year. Nearly all states enroll some or all their beneficiaries into Medicaid managed care plans.

Patient access to the health care system is eroding as some commercial health plans restrict access to health care services by inappropriately denying covered services that are medically necessary, requiring unreasonable levels of documentation to demonstrate clinical appropriateness, and changing health plan rules in the middle of a contract year. For example, prior authorization — one of the most widely used utilization management tools — is designed to help patients obtain the right care in the right place. Its use is intended to ensure that providers order care that is consistent with clinical guidelines and protocols, as well as to confirm that such care is covered by the patient's plan. However, some commercial health plans are applying prior authorization to a wide range of services, including those for which the treatment protocol has remained the same for decades and there is no evidence of abuse.

Misuse of utilization management tools like prior authorization has several negative implications for patients and the health care system. Prior authorization denials can result in delays of necessary treatment for patients and ultimately lead to unexpected medical bills. The extensive approval process that doctors and nurses must go through adds wasted dollars to the health care system through overuse of prior authorization, inefficient submission processes, excessive requests for unnecessary documentation and the need to reprocess inappropriate payment and coverage denials. These practices also are a major burden to the health care workforce and contribute to clinician burnout.ⁱⁱ A May 2022 advisory issued by Surgeon General Vivek Murthy, M.D., notes that burdensome documentation and prior authorization requirements are key drivers of health care worker burnout, which exacerbate health care workforce shortages.ⁱⁱⁱ

Prior authorization denials can result in:

-  delays of necessary and timely treatment
-  unexpected medical bills
-  billions of wasted dollars
-  clinician burnout due to administrative requirements

Further evidence of the negative impact of these practices is mounting. The Department of Health & Human Services Office of Inspector General (OIG) issued an alarming report in April 2022 highlighting that inappropriate and excessive denials for prior authorization and coverage of medically necessary services is a pervasive problem among certain plans in the MA program.^{iv} Using a random sample of denials from the one-week period of June 1–7, 2019, **the report found that 13% of prior authorization denials and 18% of payment denials actually met Medicare coverage rules and should have been approved.** In a program the size of MA, this rate of improper denials is deeply concerning.

While the numbers alone are concerning, the report also describes the human impact of these delays and denials on patients. Just consider the following examples described in the report:

- A 72-year-old woman presented with a cancerous breast tumor. **The MA plan denied her breast reconstruction surgery**, stating “that the service was not covered.”^{vii} That decision was reversed after the OIG requested data from the insurer.
- **An MA plan denied authorization for a 67-year-old patient to move to an inpatient rehabilitation facility, even though he presented with an “acute right-sided ischemic stroke and [was] seen at the emergency department with new onset slurred speech.”**^{viii} “The beneficiary had difficulty swallowing, was at significant risk of aspiration and fluid penetration, at high risk for pneumonia, and, therefore should have been under the frequent supervision of a rehabilitation physician.”
- **An MA plan refused to pay \$150 a month for a hospital bed with rails**, even though a 93-year-old patient had a history of epilepsy, early-onset Alzheimer’s, rheumatoid arthritis, chronic back pain, knee and joint stiffness, and limited range of motion.^{ix} OIG’s medical experts determined that this bed request was medically necessary “due to the beneficiary’s chronic conditions and movement limitations.”^x

These findings reiterate a similar OIG report published in September 2018 that warned that high rates of MA health plan payment denials and prior authorization delays could negatively impact patients' access to care.^{xi}

Government agencies, as well as courts and arbitrators, have uncovered other troubling findings. Last year, a Nevada jury ordered UnitedHealthcare to pay a group of emergency room physicians \$60 million in punitive damages for intentionally underpaying them by millions of dollars.^{xii} Earlier this year, Georgia's Insurance Commissioner fined an Anthem (now Elevance) plan \$5 million for improper claims settlement practices and violation of other state standards.^{xiii} Notably, transparency data reported to CMS by Elevance (formerly Anthem) show consistently higher-than-average denial rates for in-network claims compared to peer plans offered on the Health Insurance Marketplaces in all but one year between 2015-2020.¹ More recently, in May 2022, an arbitrator ordered the same insurer to pay a group of 11 acute care hospitals in Indiana \$4.5 million as compensation for processing claims for emergency services that the arbitrator found to be a clear violation of federal and state law.^{xiv}

It also is noteworthy that in response to COVID-19, many health insurers were urged by government agencies to scale back the use of many of these tactics precisely because they can create barriers to care. State governments, as the primary regulators of insurance, also have acted. For example, New York State passed several insurer accountability measures at the beginning of the COVID-19 pandemic to help ensure patient access to care and to remove unnecessary burdens on providers on the front lines.^{xv}

Integrated Health Systems with Insurance Offerings

Not all health insurers adopt the same policies and practices. Hospitals and health systems routinely report that certain large, national commercial insurers more frequently adopt the problematic practices described in this report. In contrast, hospitals and health systems frequently note more positive working relationships with smaller, community-based plans, including those that are part of integrated health systems.

Integrated health systems that offer insurance plans have shown to be beacons of innovation. As a result of being more readily able to coordinate across and align the delivery system and health insurance benefits, these organizations have been able to develop and test new approaches to things like prior authorization. For example, one integrated delivery system with a health plan recently eliminated a substantial number of prior authorizations for patients cared for in their system to help achieve their care coordination and efficiency objectives. We see considerable opportunity for solutions development within integrated health systems that offer insurance plans, as well as between other health insurers that are willing to work collaboratively with their network providers.

¹ The Affordable Care Act (ACA) requires insurers to report certain transparency-in-coverage data to CMS and other regulators; however, these requirements do not apply to all types of coverage, including non-group plans, employer-sponsored plans, or MA plans.

Prior Authorization

Prior authorization is a process whereby a provider, on behalf of a patient, requests approval from the health plan before delivering a treatment or service to qualify for coverage and payment by the health plan. According to AHIP, prior authorization is implemented by health plans “to help ensure patients receive optimal care based on well-established evidence of efficacy and safety, while providing benefit to the individual patient.”^{xvi} Philosophically, we agree with these laudable goals; indeed, some health plans use prior authorization in ways that accomplish them. **However, many health plans apply prior authorization requirements in ways that can create dangerous delays in care, contribute to clinician burnout and drive up health system costs.**

Inappropriate use of prior authorization can negatively impact the quality of care. **A 2021 survey of more than 1,000 physicians found that more than 90% of respondents said prior authorization “had a significant or somewhat negative clinical impact, with 34% reporting that prior authorization had led to a serious adverse event such as a death, hospitalization, disability or permanent bodily damage, or other life-threatening event for a patient in their care.”**^{xvii,xviii} **In addition, 93% of the physicians surveyed reported that prior authorizations result in delays in accessing necessary care.** The federal government also has acknowledged the risk of delays in care caused by prior authorization requirements, which is why CMS urged health plans to ease such requirements during the COVID-19 public health emergency. Specifically, CMS stated that “new guidance for individual and small group health plans encourages issuers to utilize flexibilities related to utilization management processes, as permitted by state law, to ensure that staff at hospitals, clinics, and pharmacies can focus on care delivery and ensure that patients do not experience care delays.”^{xix}

Prior authorization also puts a heavy burden on clinicians and contributes to workforce burnout. According to the National Academies of Medicine, “among clinicians, burnout is associated with job demands related to workload, time pressure, and work inefficiencies, such as burdensome administrative processes which divert clinicians’ attention away from patients and detract from patient care.”^{xx} Prior authorization is one of the administrative processes most frequently cited by clinicians as a contributing factor to burnout. A few real-world examples of the burden associated with prior authorization include²:

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Some commercial health plans are applying prior authorization to services for which the treatment protocol has remained the same for decades and there is no evidence of abuse.

² These examples were reported to AHA by member hospitals separate from the 2021-2022 survey data collection process.

- One 20-hospital system spends \$17.5 million annually complying with prior authorization requirements.
- A single 355-bed psychiatric facility needs 24 full-time equivalents (FTEs) to deal with authorizations.
- A large, national system spends \$10 million per month in administrative costs associated with managing health plan contracts, including two to three full-time staff that do nothing but monitor plan bulletins for changes to the rules.
- A large health system conservatively estimates that the negative financial impact of managing prior authorizations for all services (excluding transplant procedures and prior authorizations secured in decentralized clinic locations) was about \$18.2 million in 2019, roughly \$3.6 million of which was lost revenue due to cancellations and rescheduling because of prior authorization delays. This system requires 65 FTEs to handle prior authorizations; eight additional FTEs to notify insurance companies of unplanned, urgent and emergency admissions; another team in utilization management to handle concurrent reviews with insurers and handle disputes over inpatient or outpatient status when the patient is admitted; and two denial management staff who advocate for patients experiencing denials.^{xxi}
- Physicians report that their offices spend, on average, two business days of the week dealing with prior authorization requests, with 88% rating the burden level as high or extremely high.^{xxii}

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The costs associated with prior authorization go beyond workforce burnout. These processes require significant technological infrastructure and staff time, and delays often mean that a patient consumes more health care resources than required, e.g., by remaining in an inpatient bed when they should have already been discharged to another site of care. Health insurers rarely pay for those additional days of inpatient care, forcing the health care system to absorb those costs.^{xxiii} This is especially common for patients experiencing a behavioral health crisis or for those who require post-acute care. These patients are often kept in an emergency department or an inpatient hospital setting awaiting authorization to transfer to another facility.

Why is the administrative burden so cumbersome? Reasons include:

- **Variation in Submission Processes.** Insurers vary widely on accepted methods of prior authorization requests and supporting documentation submission. While some insurers

accept electronic means, many continue to rely on fax machines and call centers, with regular hold times of 20 to 30 minutes. Additionally, insurers offering electronic methods of submission most commonly use proprietary plan portals, which require a significant amount of time spent logging into a system, extracting data from the provider's clinical system and completing idiosyncratic insurer-specific requirements. Providers and their staff must ensure they are following the right rules and processes for each individual plan, which may change from one request to the next. The tremendous amount of variation in the requirements and processes means that, inevitably, providers commit inadvertent errors that result in denials that must be reprocessed or appealed.

- **Inappropriate Application of Prior Authorization.** Health insurers increase administrative burden when they broadly apply prior authorization even to services or treatment protocols that are neither new nor have a history of unwarranted variation. For example, one respondent to the 2019 AHA survey indicated that they had cared for a patient newly diagnosed with diabetes who presented with a fasting blood glucose level of 520 mg/dL. Despite this level being at a critically dangerous five times the acceptable range, the patient's health plan informed the treating clinician that insulin, a standard lifesaving medication that has been widely used for nearly 100 years, was subject to prior authorization and review would take up to 24 hours. The clinician was forced to provide the patient with samples to immediately start treatment while awaiting the insurer's decision.
- **Unreasonable or Unrelated Requests for Documentation.** As part of their review of medical necessity, insurers will often request voluminous amounts of documentation, which is often duplicative to previous requests, or in some cases entirely unnecessary for determining whether a service is appropriate. This frequently occurs for long stays, high-dollar accounts, and higher acuity care, and can result in diminished access to and payment for covered services. In fact, the 2022 OIG report concluded that "Medicare Advantage Organizations (MAOs) indicated that some prior authorization requests did not have enough documentation to support approval, yet our reviewers found that the existing beneficiary medical records were sufficient to support the medical necessity of the services."^{xxiv} In other cases, the OIG reported that MA plan reviewers asked for copies of documentation already contained in the patient case file.

For example, according to OIG reviewers, an MA plan denied a request for Botox medication for a beneficiary with a diagnosis of urge incontinence (estimated cost \$3,674). The MA plan incorrectly stated that there was a lack of clinical information about the beneficiary's previous use of the medication and asked for additional records. However, the MA plan had already received records documenting the beneficiary's previous use of Botox as part of the prior authorization request, making the request for the documentation unnecessary.^{xxv} (The MA plan reversed the denial after receiving OIG's data request.)

- **Insufficient Personnel or Network Gaps.** Some insurers do not have the personnel to process the growing number of prior authorization requests. A limited sample of 98 hospitals and health systems from our 2019 survey reported approximately 865,000 prior authorization requests in 2018 to which insurers did not respond at all and which required follow-up by the provider. This most frequently occurs when the patient comes in overnight or on the weekend when the insurer does not have staff available to review routine requests. In fact, 92% of respondents to the survey reported having contracts with insurers that do not have prior authorization review available around the clock, seven days a week.

In other instances, prior authorization delays may be caused by inadequate provider networks. Although plans participating in government programs (i.e., Medicare Advantage, Medicaid managed care) are required to meet network adequacy standards, referring providers who have had trouble finding placements for patients have cited inadequate in-network options as a contributing factor for delays. In some cases, inadequate networks may be a result of provider shortages in a community; however, in others, they appear to be the result of insufficient contracts between the plan and providers. Hospitals report the greatest challenges in obtaining patient access to inpatient mental health/substance use disorder recovery services, medication assisted therapy, long-term acute care hospital services, and home health service. These shortcomings impede timely access to care and require patients to stay in general acute care hospital beds longer than medically necessary.^{xxvii}

Under most reimbursement structures, **insurers do not compensate hospitals for the care provided during these delays.** Specifically, under episode- based payments, like MS-DRGs, hospitals receive a fixed payment for each hospital stay, regardless of the number of days the patient is in the hospital. The insurer does not pay more for any additional days the patient spends in the hospital unnecessarily. In fact, insurers may save money as a result of delaying or denying discharge to the next appropriate setting to the extent the hospital continues providing services and the patient's condition improves to the point of no longer requiring the same next level of post-acute care.

- **Denials of Unanticipated but Medically Necessary Care.** It is not always possible to know in advance everything a patient may need during a procedure. Providers will obtain

A patient with traumatic brain injury was medically ready for discharge but sat for four additional days in the hospital without access to essential post-acute care because the insurer had not responded to the provider's request to move the patient into a rehabilitation facility.^{xxvi} Another AHA member that operates inpatient rehabilitation facilities reports that 11% of their MA referrals take 10 days or longer to resolve. These delays in moving patients has resulted in tremendous strain on general acute care hospital capacity, which has been particularly critical during the COVID-19 pandemic when hospitals have been in desperate need of inpatient beds to care for COVID-19 patients.

authorization for the primary procedure and what they expect to be any ancillary items and services. However, it is not uncommon once a treatment or procedure is underway for the clinician to discover new information that necessitates other items and services to deliver the best patient care. A common reason that this may occur is when a patient's condition changes quickly during a procedure, perhaps necessitating an emergent response or intervention. It is not uncommon for an insurer to deny coverage for an item or service not pre-authorized, even if the overall procedure was approved. For example, a provider may have received authorization from the patient's insurer for a colonoscopy, but a bleed or lesion discovered during the procedure may require additional intervention, such as removal of the lesion, which could not have been known or authorized in advance. This approach is inconsistent with the nature of medical procedures and treatments and may narrow necessary treatment options or result in providers being unpaid for medically necessary care they appropriately provided.

- **Appeals of Inappropriate Denials.** Medical necessity is one of the most common reasons that prior authorization requests are denied.^{xxviii} However, hospitals and health systems frequently experience situations where certain insurers routinely deny medically necessary care, which then requires additional staff time and resources to appeal. For example, one hospital reported through our 2019 survey that an insurer denied prior authorization for the hospitalization of a young adult experiencing their first psychotic episode because there was no prior history of psychosis for that patient.^{xxx}

The denial of medically necessary care was highlighted by the 2018 OIG report, which found that MA plans overturned 75% of denials that were appealed between 2014 and 2016.^{xxix} The 2022 OIG report identified several factors contributing to inappropriate denials, which include the use of proprietary clinical criteria and health insurer staff without suitable clinical knowledge. Health insurers frequently modify broadly available clinical guidelines, and these modifications are not always shared with providers. In addition, hospitals and health systems report that some insurers' clinical reviewers often do not have the requisite expertise. For example, an insurer may assign a urologist to assess whether a cancer patient should receive the type of chemotherapy

referred by the treating oncologist.^{xxxii} These issues are further compounded by processing errors, according to the OIG report, which highlights a variety of human and systemic plan processing issues that result in inappropriate denials of care or payment.

Consistent with the 2018 OIG report findings, AHA survey data from 2021-2022 reflects that most prior authorization and claim denials that are appealed are ultimately overturned in the providers’ favor (Table 2). However, health plans continue to deny a substantial portion of prior authorizations (Table 1).

Table 1: Inpatient Prior Authorization Initial Denial Rates

Product Type	Inpatient Prior Authorization Denial Rate
Medicaid Managed Care	15.5%
FFS Medicaid	7.6%
Medicare Advantage ³	19.1%
Commercial	11.4%

Table 2: Overturn Rate for Inpatient Prior Authorization Denial Appeals

Product Type	Overturn Rate
Medicaid Managed Care	61%
FFS Medicaid	69%
Medicare Advantage	69%
Commercial	68%

35%
of hospitals and health systems report
\$50 Million
or more in foregone revenue as a result of denied claims once appeals have been exhausted

Table 1 reflects that the rate of prior authorization delays and denials is not uniform across all insurer health plan products. Our most recent survey data shows that commercial insurers serving public programs are more likely to deny inpatient prior authorization requests. Specifically, MA plans have the highest inpatient prior authorization denial rate, followed by Medicaid managed care and commercial products. These rates vary despite physicians following the same clinical guidelines regardless of a patient’s type of coverage.

³ Traditional Medicare is not included in this table because it does not typically apply prior authorization on the same scale as commercial insurers and MA plans. However, these differences underscore the disparity in access to care between Medicare beneficiaries enrolled in traditional Medicare and those enrolled in MA, whose care is subject to a variety of other barriers and utilization management protocols that are not applied to traditional Medicare enrollees.



Reimbursement Delays and Denials

Some commercial health insurers are increasingly delaying and denying coverage of medically necessary care, a trend that continued in 2020 despite the emergence of the COVID-19 pandemic.^{xxxiii} Yet, approximately half of all claims denials that are appealed are ultimately overturned. And even in cases where the denial stands, the 2022 OIG report shows that a portion of those upheld denials were for care that should have been covered.

The financial consequences of these delays and denials for health care providers can be significant, even in cases where a denial is overturned on appeal. In our most recent survey, 50% of hospitals and health systems reported having more than \$100 million in accounts receivable for claims that are older than six months. This amounts to \$6.4 billion in delayed or potentially unpaid claims that are six months old or more among the 772 reporting hospitals, leaving providers with untenable financial liability.^{xxxiv} Furthermore, 35% of survey respondents reported \$50 million or more in foregone revenue as a result of denied claims after all appeals have been exhausted.

These payment delays and denials for medically necessary care have serious implications for the financial stability of health care providers and compound fiscal challenges plaguing our health care system. In 2022, more than 50% of hospitals are projected to end the year with negative operating margins. The cost of caring for patients has increased by nearly 20% since pre-pandemic levels due to unprecedented surges in labor and supply costs, as well as staffing issues and inflation. Expenses for hospitals and health systems are projected to increase by \$135 billion over 2021 levels, driven largely by labor costs. Inappropriate payment delays and denials exacerbate these financial challenges. One 133-bed rural hospital reported experiencing 180 MA denials in the last six months alone, which translated to nearly \$1.2 million of disputed reimbursement for services already rendered, or approximately \$2.4 million annualized.^{xxxv} Absorbing financial losses of this magnitude is simply untenable for the majority of hospitals and health systems.

Below are several common reasons why claims can end up disputed in whole or part:

- **Failure to Obtain Prior Authorization.** To prevent harm and adequately care for patients, providers sometimes must begin treatment or move a patient to a more appropriate site of care before obtaining a response to a prior authorization request. In such instances, some insurers will deny care that they acknowledge to be medically necessary simply because the provider did not wait for the prior authorization approval.
- **Basing Medical Necessity Determinations on Information Only Known After the Fact.** Some insurers adjudicate medical necessity based on information known about the patient's condition after the care was provided. For example, it is not uncommon for some

insurers to downcode a claim if the diagnostic results show that the patient has a less severe condition than was known prior to the test having been completed.

- **Observation Status/Short Stay Denials.** Hospitals and health systems report a steep increase in short stay denials, even when clinical indicators and the severity of illness meet the standards for inpatient admission. In these instances, some insurers downcode the inpatient claims to observation status. In our most recent survey, approximately 75% of respondents noted that insurers are reimbursing more care as observation instead of inpatient.^{xxxvi} This is supported by an AHA analysis of data from Strata Decision Technology’s StrataSphere data set showing that the length of stay for observation cases has increased across all payers since 2019, but that this trend is particularly pronounced in MA, where the length of stay for observation has increased by 15.6% from 2019 to 2022.^{xxxvii}

In some cases, hospitals report that insurers will request the provider resubmit a claim as observation instead of inpatient for the claim to be paid. In effect, this results in underpayment to the provider and ensures the transaction does not appear as a denial so long as the provider agrees to resubmit. This practice obscures the true prevalence of denials and often results in providers accepting lower levels of payment to avoid prolonged payment delays and costly escalations or appeals.

- **Sepsis.** Several of the large, commercial insurers are now reimbursing providers for sepsis care using the Sepsis-3 clinical criteria, instead of the broadly adopted Sepsis-2. The primary difference between the two sets of criteria is that Sepsis-3 recognizes more severe forms of sepsis. This is a payment policy, not a change in clinical guidelines. Specifically, by basing provider payment on Sepsis-3, these insurers are declining to reimburse providers for early sepsis interventions. However, they are not requesting or requiring providers to stop treating early cases of sepsis; they simply will not pay for care provided to patients in the early stages of sepsis. These payment policy changes are inconsistent with the CMS sepsis quality measure (“Severe Sepsis and Septic Shock: Management Bundle”), as well as some state laws. Indeed, the CMS has expressly rejected adoption of Sepsis-3.^{xxxviii} One independent hospital noted that this insurer practice results in a per-case reduction in reimbursement ranging from \$500 to \$6,000 depending upon the factors involved. This represents a loss of more than \$100,000 annually for this single hospital.^{xxxix}

Further, adoption of the Sepsis-3 criteria introduces conflict and confusion in the field around the appropriate clinical pathway and signals a retreat on standardization of clinical care. Early treatment is critical to prevent the progression of sepsis and any reduction in early intervention could result in increased mortality. The misguided adoption of Sepsis-3 clinical criteria results in underpayment for these very critical early interventions. This change misaligns incentives among providers and insurers to achieve a shared goal of reducing sepsis, which can be a life-threatening condition for patients.

- **Site of Service Exclusions.** Several insurers will only cover services when provided in certain sites of care. While these policies may in part be intended to drive care to the most cost-effective site of care, they often do not take into account the full range of considerations for when a patient may need a higher level of care. In addition, certain insurers implement such policies unilaterally in the middle of a contract cycle, which has the effect of changing enrollees' coverage mid-year.

In practice, this means that consumers evaluated and selected their coverage options based on one set of rules, only to find themselves with a different health plan product with little recourse. This creates a barrier to patients understanding their coverage, and in some circumstances, to continuing treatment with their established providers.

Site of service policies are most often applied to certain diagnostic tests and surgical procedures; however, they also have been applied in the emergency setting. Specifically, some large commercial insurers have questioned patients' use of the emergency department without full regard as to why the individual sought emergency services. These decisions may provide a disincentive for patients to seek emergency treatment in the future. Avoiding necessary emergency treatment could result in serious harm to or death of a patient.

These site of service exclusions also make the coordination of routine and chronic care more difficult. These policies often require that patients go to alternate sites of care that are unaffiliated with their primary providers, cannot offer the exact service required (most frequently an issue with certain types of sophisticated imaging), or cannot easily communicate results back to the referring provider. For example, some insurers have implemented site of care policies for certain specialty medications that require patients to travel to off-site freestanding infusion centers. These practices can cause stress for patients with complex illnesses such as cancer, who can no longer receive infusions at their primary provider. It also creates additional challenges for providers to maintain accurate records of doses administered in unaffiliated facilities, which can impede medication reconciliation and monitoring of side effects, creating further safety risks.

- **White Bagging Requirements.** Certain insurers require health care providers to obtain physician-administered drugs from the insurer's owned or affiliated specialty pharmacy instead of allowing the health care facility to provide the drug on-site from its own inventory; this practice is known as "white bagging." When unilaterally imposed by an insurer, white bagging may create safety concerns or result in delays in patient care, while potentially adding additional cost and burden to the health care system. These practices appear to be growing because of vertical integration between pharmacy benefit managers and large health insurance companies.

Specific safety issues and administrative burdens that can result from white bagging mandates include:

- Circumventing established safety systems designed to ensure safe ordering and management of patient medications in a health care facility;
- Causing delays in time-sensitive patient care when medications are not delivered or are shipped late by the external pharmacy, or if changes in a patient’s treatment plan or dosing requires more medication than was provided by the third-party pharmacy;
- Inhibiting health care providers from validating that specialty medications, which often have specific temperature and handling requirements, were managed appropriately throughout the supply chain and delivery processes and are safe to administer to patients; and
- Creating opportunities for error by requiring hospitals to develop and maintain a separate inventory of drugs for individual patients subject to white bagging policies.

An oncology patient was scheduled to receive an infusion drug, but their insurer required white bagging, even though the drug was readily available through the hospital pharmacy. The drug was left in the truck overnight, rendering it unusable. The service had to be cancelled and subsequently was delayed several additional weeks following further problems in obtaining the drug from the third-party specialty pharmacy due to weather-related delivery delays. Concerned for the patient’s health, the hospital team continued to press the insurer to approve use of the hospital’s stock to prevent harm to the patient. The insurer finally approved one dose from the hospital stock, but no more.^{x1}

- **Inaccurate Enrollment Files.** Claims denials also occur because of inaccurate enrollment files. These errors can occur both when the insurer indicates the patient does not have active coverage when they actually do, as well as when an insurer pays a claim only to subsequently realize the patient is no longer enrolled in their plan and recoup the payment. In the latter scenario, the correct payer often will not allow retroactive authorization and denies the claim as well, leaving the provider with unreimbursed costs for medically necessary care. These problems occur most frequently in the first quarter of the year when insurer membership files may not be fully up to date.
- **Inadequate Vendor (or Delegated Entity) Oversight.** Many insurers contract with vendors or other delegated entities to analyze claims and make prior authorization and reimbursement determinations. These third parties are not always in sync with the insurers’ rules and policies, which can contribute to inappropriate delays and denials, as well as difficulty escalating issues to the appropriate staff. For example, hospitals and health systems report being told one thing by the insurer only to be told another by the vendor, such as whether prior authorization is required. Hospitals and health systems report that they are frequently unable to communicate with insurers on these issues

because they are not provided accurate contact information and often get caught in endless automated voice answering service loops or directed back to the vendor again. While vendors contracted with MA plans and Medicaid managed care plans are required to follow applicable state and federal rules that apply to the plan, there does not appear to be sufficient oversight of vendor activities on behalf of commercial health plans.

Third- and fourth-party vendors. An insurer with more than 20 million members uses a third-party vendor to manage imaging authorizations and a fourth-party vendor to direct patients to facilities it determines to be lower in cost. The third-party authorization vendor will not issue an authorization until the provider contacts the fourth-party vendor to gain approval for the patient's selected location. One health system reported their staff spends on average 20 minutes for each patient in conversations with the fourth-party vendor for one insurer, which not infrequently results in selecting the original location as planned.^{xli}

Patients and the providers who care for them deserve a rational, predictable and efficient system to ensure access to high-quality care. Below are a series of policy solutions to ensure fair prior authorization and payment policies and procedures. Implementing standards for prior authorization would better ensure that patients receive timely access to the services they need while reducing substantial cost and burden on the health care system. Many of these recommendations align with the Improving Seniors' Timely Access to Care Act, federal legislation that would streamline prior authorization processes in the MA program. That legislation is currently under consideration in the U.S. Senate after passing the U.S. House of Representatives. However, it will not address prior authorization in other types of coverage.

We recognize that standardization will require effort on the part of all parties, including by requiring providers to adjust their technology applications and implement new workflows. However, we believe it is critical to take on this additional effort in the short term to reduce the complexity and burden associated with prior authorization over time.

1. Standardize Prior Authorization Requirements and Processes. The AHA supports streamlining prior authorization processes in the following ways:^{xlii}

- **Standardize the format for communicating services subject to prior authorization.** While insurers generally provide lists of services subject to prior authorization via their websites, it can be challenging for providers to locate the right list for the right plan and keep up with any changes, especially when insurers and their vendors provide inconsistent information. Insurers should adhere to a standard format for posting prior authorization requirements, provide accurate staff contact information for follow-up, and ensure oversight of vendors. Ideally this information could be conveyed within a provider's clinical information system, which would ensure that the provider knows when developing a treatment plan whether prior authorization is required.
- **Standardize the format for prior authorization requests and responses.** All prior authorization requests and responses should be transmitted using a standardized electronic format, including the submission of clinical documentation. The format for requests should have standardized fields for the clinical information required. Denials should include a detailed rationale. Where feasible, electronic standards should integrate with provider clinical information systems to eliminate time spent transposing clinical data from one system to another. Alternate mechanisms, such as fax, only should be used in rare circumstances, such as in areas with limited broadband or other technical limitations. One member estimates that switching from verbal/fax processes to an electronic transmission process would reduce the amount

of provider staff time for each request by at least 50% — from a current average of 30 to 45 minutes per request to 15 minutes per request.

- **Require 24/7 prior authorization capabilities.** Hospitals care for patients 24 hours a day, 365 days a year. To prevent patients from waiting unnecessarily for care, often in the emergency department, insurers should be required to have staff available 24 hours, seven days a week to respond to prior authorization requests.
- **Establish timely response requirements.** Insurers should abide by the same timeframes for responses: 72 hours for certain scheduled, non-urgent services and 24 hours for urgent services. The clock should begin when the provider submits the request with the information available at the time the provider's request is made. There also should be a period of retroactive consideration of prior authorization requests for urgent services for which the patient's clinical condition warranted immediate intervention or for situations when prior authorization was not possible (e.g., a patient's condition changes during a procedure or treatment requiring a change in the course of care).
- **Require full and complete denial notices.** Insurers should communicate denials in writing and transmit them electronically. Denial letters must include specific information on the rationale for the denial so that the provider knows exactly what is required to appeal.^{xliii}
- **Standardize appeals processes.** Insurers should follow a standard appeals process, which should include an opportunity for external review of denials. In addition, insurers must have the ability to conduct timely peer-to-peer consultations with appeals reviewed by someone with the appropriate level of clinical knowledge and training on the particular service.

Value-based Purchasing as Part of the Solution

Value-based purchasing (VBP) arrangements may be part of the solution to reduce the administrative burdens inherent in many health insurer/provider interactions. Specifically, VBP models that compensate providers on a capitated or sub-capitated basis may reduce or eliminate health insurer prior authorization requirements, as well as individual claims adjudication. The provider assumes primary responsibility for not only access to and quality of care, but also managing the financial risk associated with a given population.

Hospitals and health systems are eager to explore these arrangements with insurers but have faced considerable barriers to doing so. Not only do they require substantial resources to erect, but successful arrangements require alignment across both parties to achieve a common objective for the patient population served. This means that the insurer and the provider must agree to the objectives and parameters of the relationship, ensure clarity regarding responsibilities for care management, set performance metrics and targets, and agree to common technology and information sharing. These are highly complex arrangements that require willing and committed partners with dedicated staff and near constant communication. It can be challenging for providers who routinely contract with many different insurers to participate in even just a few payer-specific models at once. Ideally, providers and payers would be aligned under multi-payer contracts to reduce variation in metrics and align under a consistent payment model.

Despite this interest, many hospitals and health systems report that the large, commercial insurers in their communities have been uninterested or unwilling to enter into capitated payment arrangements. The AHA believes there is significant opportunity for collaboration between insurers and providers to advance adoption of VBP arrangements that support patient access to quality care.

2. Increase Oversight to Prevent Inappropriate Prior Authorization and Payment Delays and

Denials. Regulators should conduct routine oversight to ensure that patients have access to covered services, that the rules are fair for contract providers, and that, as appropriate, taxpayer dollars are well-spent. We encourage improving oversight in the following ways:

- **Improve data collection and public reporting.** Regulators should require reporting of standardized performance measures related to prior authorization and payment delays and denials, including the rate of denials overturned upon appeal, at the plan level. This information is necessary for policymakers and regulators to conduct appropriate oversight of health insurance rules and should be available for public review as well.

- **Set thresholds.** Oversight bodies should establish thresholds for “appropriate” levels of prior authorization and payment delays and denials to identify and target potential bad actors for increased scrutiny. Plans identified as such should be subject to more frequent audits for suspected or potential violation of federal rules.
- **Apply financial penalties for inappropriate denials.** Regulators should create a financial disincentive for plans to inappropriately deny prior authorization requests or claims for reimbursement. This may take the form of a penalty paid to the government in instances where an insurer has a high rate of inappropriate delays or denials or an additional fee paid to the provider for denials that are overturned on appeal.
- **Ensure adequate provider networks.** Inadequate networks may contribute to prior authorization delays, and we urge regulators to further explore the relationship between the two. This may be accomplished through routinely testing health plan’s networks (or delegated network), including through “secret shopping” efforts to ensure that providers are indeed in- network and accepting patients from that health plan or a delegate.

Role of Contracts in Dispute Resolution

Insurers and providers enter into contracts to define the terms of their agreements, including things such as reimbursement, network participation, licensing and insurance requirements, and credentialing. Insurers also use provider manuals to further elaborate on certain elements of the contract, especially how certain provisions may be operationalized, such as prior authorization requirements and appeals processes. These manuals often can be changed by the insurer during the contract period.

Contracts are one of the most important tools that insurers and providers have to ensure that the terms of the relationship are fair and allow for appropriate redress if either party violates a term.

However, contracts are limited by certain factors, including the relative negotiating power of each party and that enforcement of the terms can be expensive and lengthy. Terms or requirements that should be universally adopted may more appropriately be handled through federal or state policy. An example of this is prompt pay policies, which not only help efficient processing of claims but also ensure that patients receive bills in a timely manner.



Conclusion

Patients and their network providers should not face unnecessary or inappropriate barriers to care. Recent trends in prior authorization and payment delays and denials suggest that certain commercial health insurer practices threaten patient access to care and drive excessive administrative costs and burden in the health care system. Regulators should ensure appropriate oversight of insurers, as well as streamline prior authorization requirements and processes. These efforts will go a long way to allow for a more rational, navigable health system for patients and reduce addressing unnecessary costs and burdens in the system.

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