



Analysis

Prior Authorization in California

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SUMMARY

Prior authorization is a type of utilization management technique¹ used by health plans and insurers to ensure safety and appropriateness of medical and pharmacy services, reduce low-value care,² and control costs. A challenge for policymakers, payers, patients, and providers is that prior authorization is generally intended to decrease costs and waste, but it may also contribute to delays in treatment and additional barriers to care.³ Currently, evidence is limited as to the extent to which health insurance throughout the United States, and more specifically state-regulated health insurance in California, uses prior authorization and its impact on the performance of the health care system, patient access to appropriate care, and the health and financial interests of the general public.

What Is Prior Authorization?

Prior authorization (also called “preauthorization” and “precertification”) refers to a requirement by health plans and insurers for patients to obtain approval of a health care service or medication before the care is provided. This allows the plan or payer to evaluate whether care is medically necessary and otherwise covered. Other utilization management tools that may be used in conjunction with or separately from prior authorization include step therapy, preferred and nonpreferred medications, and cost sharing. Results from the California Health Benefits Review Program (CHBRP) health plan survey indicate that the principal reasons cited by state-regulated health plans/insurers for implementing prior authorization requirements were related to improving patient safety and health outcomes, reducing unnecessary care, ensuring continuity of care, and cost containment.

Why Is Prior Authorization Used?

One common reason prior authorization is used is to reduce and control health care spending. Total national health expenditures as a share of the gross domestic product have increased steadily over time. While the overall increase in health care spending can be largely attributed to increased cost of services and increased utilization, there is another important piece that drives both increased utilization and cost of services. Unnecessary medical care or wasteful health care spending, such as administrative

complexities and fraud, are additional drivers. A recent study estimates that between 20% and 25% of all health care spending in the United States is a result of wasteful and unnecessary spending, as well as missed opportunities to provide appropriate care.

Health plans/insurers operating in California responding to CHBRP’s query on areas of highest fraud and abuse noted that waste and abuse may occur more frequently when low-value or medically unnecessary care is delivered. Behavioral health – particularly applied behavioral analysis – was identified by health plans/insurers as a leading fraud risk. State-regulated health plans/insurers also report fraud for services and medications provided under the pharmacy benefit. Responding health plans/insurers described accounts of falsification of prior authorizations, inappropriate billing practices, and provision of unnecessary (and unrequested by patients) billable products by certain entities, including pharmacies and telehealth entrepreneurs.

Impact of Prior Authorization

The peer-reviewed literature base evaluating the impact of prior authorization is relatively limited. Much of the published literature regarding the impact of prior authorization focuses on prescription medications. Additionally, prior authorization is commonly grouped together with other utilization management techniques, such as step therapy, preferred/nonpreferred medication lists, and cost sharing. Study findings

¹ Utilization management techniques include benefit coverage requirements related to prior authorization, step therapy, quantity limits.

² Low-value care can be defined as services that provide little or no benefit to patients, have potential to cause harm, incur unnecessary cost to patients, or waste limited health care resources (V-BID, 2023),

³ Refer to CHBRP’s full report for full citations and references.

suggest that prior authorization interacts with other policies and programs that health plans implement to constrain utilization and cost. The combined results of these studies indicate that whereas the practice of prior authorization itself may have a significant impact on utilization of specific prescription medications, policymakers should also consider other policies that may impact utilization and uptake of the drug. Overall, the evidence regarding whether prior authorization improves patient safety, reduces excess spending, and ensures medically appropriate care is provided, is mixed.

- **Denials and appeals:** Across studies, a sizable share of prior authorization denials were overturned upon appeal, ranging from 40% to 82% of denials being overturned. The reasons for the initial denial were mostly due to submission of incomplete clinical data or insufficient documentation of medical necessity. In some instances when prior authorization as denied, the patient paid out of pocket for the service due to lack of coverage. Additionally, several studies have found that prior authorization created delays in treatment.
- **Utilization of medications subject to prior authorization:** Generally, evidence shows that prior authorization requirements result in lower utilization of the medication subject to prior authorization. However, studies have also shown that prior authorization decreases medication adherence.
- **Utilization of other health care services:** The evidence regarding the impact of prior authorization on the use of other health care services not subject to prior authorization is mixed. Although some studies have found prior authorization reduces emergency department visits and hospitalizations, others have found an increase in other health care services. For the impacts of prior authorization on utilization of other medications, evidence points to a shift in utilization from medications with prior authorization requirements to medications without prior authorization requirements.

- **Health outcomes:** The evidence examining health outcomes as a result of prior authorization policies is limited. While there are a few studies that demonstrate clear negative impacts of prior authorization, others demonstrate clear positive impacts. The evidence overall is mixed, making it challenging to determine whether prior authorization has an impact on health outcomes.
- **Expenditures:** Studies generally found that the impact of prior authorization on spending related to the medication or service subject to prior authorization was lower, whereas the impact on other health expenditures or total expenditures was mixed.

Additionally, there is clear frustration from both patients and providers regarding prior authorization. Complaints range from the time required to complete the initial prior authorization request and pursue denials, to delays in care, to a general lack of transparency regarding the process and criteria insurers use to evaluate prior authorization requests. People with disabilities, younger patients, those identifying as African American, and people with lower incomes were more likely to report experiencing administrative burdens, including delays in care due to prior authorization. Other aspects of medical care that contribute to waste in the health care system may be particularly impactful when prior authorization is required, such as errors in billing or recording of information within the patient's medical record or miscommunication between health care professionals.

Benefits Management in California-Regulated Insurance: Findings From a CHBRP survey

Among enrollees in state-regulated commercial plans and policies, 100% are enrolled in plans and policies with any prior authorization in the medical benefit and 48% are enrolled in plans and policies with any prior authorization in the pharmacy benefit. Overall, plans reported that between 5% and 15% of all covered medical services were subject to prior authorization requirements, along with between 16% and 25% of pharmacy services. Under the medical

benefit, services subject to prior authorization accounted for between 7% and 23% of total health plan/insurer expenditures and between 5% and 12% of total utilization of medical services.

There were significant differences among plans for the types of tests, treatments, and services requiring prior authorization. CHBRP asked for the most frequently requested prior authorization services, requests that most often did not adhere to medical-based guidelines, and the most costly. Notably, some of the most frequently requested services and treatments were not necessarily the most expensive categories of treatments and services. Many of the services under the medical benefit were those requiring ongoing care, such as behavioral health services and physical, occupational, or speech therapies. Some services and treatments were comparatively rare or more expensive albeit with comparatively low utilization rates.

Responses on trends related to prior authorization requests show high variability among health plans/insurers. This may be due to a number of factors, such as differences in the needs of their respective enrollee populations, variations in plan/insurer priorities on prior authorization at the state and/or national level, or contractual differences with risk-bearing organizations, among other possible reasons. The results of the survey show there is some consistency among health plans/insurers regarding their internal review processes.

Efforts to Improve the Prior Authorization Process

Over the years, several efforts have emerged to improve the prior authorization process. Some are focused on methods to speed up the process, such as transitioning from manual to electronic authorizations. Responses to AHIP's national survey show that a sizable share of prior authorization requests continue to be submitted manually (almost 40% for prescription medication prior authorization requests and 60% for medical service requests). However, substantial barriers exist for many providers that may contribute to the inability to submit prior authorization requests electronically, such as the financial investments required to purchase

upgraded electronic health record systems and the lack of interoperability between different electronic health record systems.

Others concentrate on minimizing its use, such as the use of "gold carding," where providers are exempt from the prior authorization process if they meet certain conditions. CHBRP's survey found virtually no adoption of gold carding for pharmacy benefits in California. A very limited number of exceptions have been made on a case-by-case basis by one responding health plan/insurer. Another responder previously gold carded a handful of providers for certain surgical services but revoked the privilege after discovery that the providers were conducting procedures inconsistent with their guidelines.

A proposed federal rule by the Centers for Medicare & Medicaid Services (CMS) intended to increase the efficiency and transparency of the prior authorization process for certain federal programs would take effect January 1, 2026.

Conclusion

CHBRP's findings indicate that prior authorization is an imperfect instrument utilized in a myriad of ways. While prior authorization is used to reduce and control health care spending (fraud, unnecessary care, and inappropriate care remain real challenges), the evidence of effectiveness is limited. Robust research remains scant on the impacts of prior authorization on patient access to appropriate care, however, some studies suggest potential harms, such as reduced medication adherence, increased use of other services, and higher overall expenditures.

Over the years, several efforts have emerged to improve the prior authorization process. It is clear that there is a need for continued work to increase the efficiency and transparency of the prior authorization process, and increase standardization across markets, payers, and health plans.

Impacts on provider time, workload, and administrative inefficiencies is another real concern, as are the burdens on patients. Achieving the twin goals of improved patient access with affordability utilizing utilization management tools like prior authorization remains a difficult bar to achieve.

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INTRODUCTION

Prior authorization is a type of utilization management technique⁴ used by health plans and insurers in the United States to ensure safety and appropriateness of medical and pharmacy services, reduce low-value care,⁵ and control costs. A challenge for policymakers, payers, patients, and providers is that prior authorization is generally intended to decrease costs, waste, and errors, but it may also contribute to delays in treatment and additional barriers to care. Currently, evidence is limited as to the extent to which health insurance throughout the United States, and more specifically state-regulated health insurance in California, uses prior authorization and its impact on the performance of the health care system, patient access to appropriate care, and the health and financial interests of the general public.

The Assembly and Senate Committees on Health have requested that the California Health Benefits Review Program (CHBRP)⁶ prepare a report to help the California Legislature understand the ways in which California state-regulated health care service plans and health insurers utilize prior authorization to control and manage covered health care services, treatments, medications, devices, durable medical equipment, and pharmaceutical products. Specifically, the Assembly and Senate Committees on Health have requested information on:

- The number and types of tests, services, and treatment that are subject to prior authorization, including the 30 health care services for which prior authorization is most frequently requested;
- Trends in approvals, modifications, denials, appeals, overturns, average length of time, etc.; and
- Evidence of impacts of prior authorization on patient outcomes and timely access to care.

To comply with the Committees' request and to provide appropriate context, this report includes:

- An introduction to prior authorization, including the process for providers and health plans/insurers;
- An overview of spending on health care in the United States, including excess health care spending and medical fraud and waste;
- A review of evidence regarding the impacts of prior authorization and patient and provider experiences;
- The use of prior authorization within Medicare, Medi-Cal, and national commercial insurers; and
- Findings from a CHBRP-administered survey of commercial California insurers.

This report does not make policy recommendations. Rather, it is intended to help policymakers better understand this complex topic.

Analytic Approach

CHBRP conducted a review of the literature and publicly available information. Key sources include peer reviewed literature, industry surveys, and relevant white papers. CHBRP also conducted a detailed survey of commercial insurers in California. This survey was sent to the state's largest (by enrollment) providers of commercial health insurance, seeking information about their prior authorization practices for tests, treatments, and services under both the medical and pharmacy benefits. Responses to surveys represent 73% of the commercial enrollees with health insurance that can be subject to state benefit mandates.⁷

⁴ Utilization management techniques include benefit coverage requirements related to prior authorization, step therapy, and quantity limits.

⁵ Low-value care can be defined as services that provide little or no benefit to patients, have potential to cause harm, incur unnecessary cost to patients, or waste limited healthcare resources (V-BID, 2023).

⁶ CHBRP's authorizing statute is available at www.chbrp.org/about_chbrp/faqs/index.php.

⁷ Survey results do not include information about prior authorization or enrollees in CalPERS or Medi-Cal managed care plans regulated by DMHC.

WHAT IS PRIOR AUTHORIZATION?

As stated previously, prior authorization is a type of utilization management technique used by health plans and insurers to ensure safety and appropriateness of medical and pharmacy services, reduce low-value care, and control costs. Prior authorization (also called “preauthorization” and “precertification”) refers to a requirement by health plans for patients to obtain approval of a health care service or medication before the care is provided. This allows the plan or payer to evaluate whether care is medically necessary and otherwise covered. Other utilization management tools that may be used in conjunction with or separately from prior authorization include step therapy, preferred and nonpreferred medications, and cost sharing. Prior authorization originated from the use of utilization reviews in the 1960s at the beginning of the Medicare and Medicaid programs, and gained substantial traction in the 1980s.

Despite the length of time prior authorization has been used, there is little information about how often it is used and for what treatments, how often authorization is denied, or how reviews affect patient care and costs (Pestaina and Pollitz, 2022).

The primary uses of prior authorization include:

- **Coverage evaluation:** Allows evaluation of whether a test, treatment, or service is medically necessary and otherwise covered.
- **Safety and appropriateness:** Acts as a safeguard to confirm that a patient’s medications are compatible and provides an opportunity to check that proper diagnostic testing has been completed prior to use of a requested treatment. Prior authorization may also reduce inappropriate patient care by stopping unsafe or low-value care that is inconsistent with the most recent clinical evidence.
- **Cost control and constraint:** Imposition of prior authorization for nonpreferred medications can encourage the use of preferred medications that can be procured at a lower price. The role of coverage evaluation to discourage low-value, inappropriate, or unnecessary care also contributes to a health plan/ insurer’s ability to control and constrain costs.

Results from the CHBRP health plan survey indicate that the principal reasons cited by state-regulated health plans/insurers for implementing prior authorization requirements were related to improving patient safety and health outcomes, reducing unnecessary care, ensuring continuity of care, and cost containment.

HOW DOES PRIOR AUTHORIZATION WORK?

General Prior Authorization Request Process

The prior authorization process for commercial health insurance typically requires providers to establish eligibility and submit documentation demonstrating medical need to the plan/insurer for approval of coverage before a medical service is provided or a prescription is filled, in order to qualify for payment. Documentation is submitted manually (i.e., via phone, mail, or fax) or electronically. The process may include several steps, depending on whether the request meets all the requirements for prior authorization approval of health plan/insurer. Requests that do not include the minimum required information for approval may be denied, in part, to meet statutory timelines required for health plans/insurers to respond to prior authorization requests. Health plans/insurers may offer “peer-to-peer review,” a process in which the ordering prescriber has a scheduled conversation with a medical director with the health plan/insurer to initially obtain a prior authorization approval or appeal a previously denied request. When appropriate, a decision to deny an original request may be overturned.

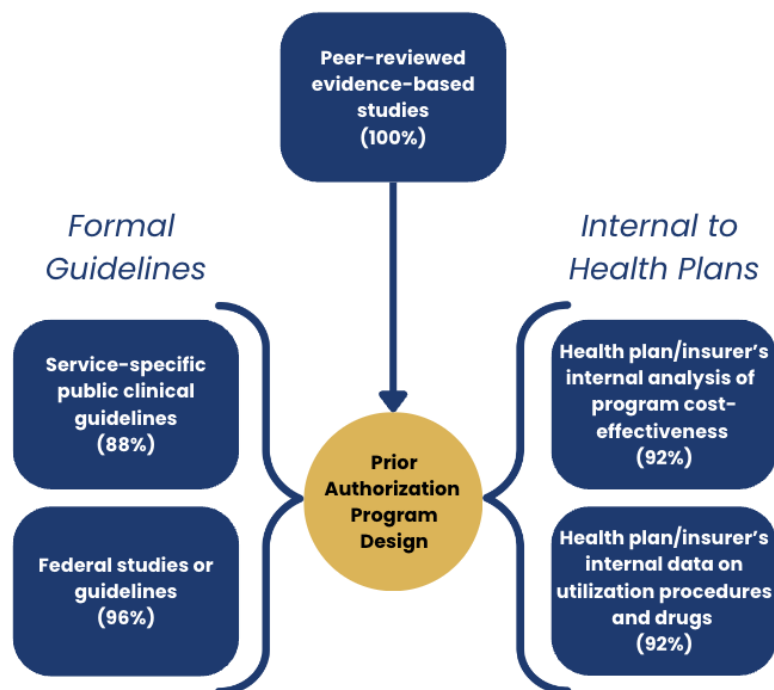
Prior Authorization Requirements

Standards and requirements for prior authorization in state-regulated health insurance are often established by health plans and insurers, based largely on medical guidelines, cost of services, utilization frequency, government regulations and statutes, and input from contracting providers and specialists (AHIP, 2019; PBMI, 2015; Pestaina and Pollitz, 2022). A recent survey from AHIP reports that among health plans surveyed, all plans rely on a range of evidence-based resources when designing prior authorization programs, including peer-reviewed evidence-based studies (100% of plans), federal studies or guidelines (96% of plans), plan’s internal data on utilization of procedures and drugs (92%), plan’s internal analysis of prior authorization program cost effectiveness (92%), and condition-specific and service-specific public clinical guidelines (88%) (Figure 1). However, there is substantial variation in prior authorization requirements between insurers. For example, studies have reported that some public payers (e.g., Medicare and Medicaid in the state of Washington) had different prior authorization requirements for atypical antipsychotics, with only 5% to 21% overlap between plans, and another study examining Medicaid plans across the country and their coverage of antirheumatic medications found similar results (Fischer et al., 2008).

Delegated Financial Risk

Within health insurance, multiple parties bear the responsibility of managing financial risk. “Financial risk” for utilization of services (responsibility for paying some or all of the costs of care) may be shifted from health plans/insurers to other entities, including medical groups. This is called a “delegated

Figure 1. Self-Reported Evidence-Based Resources Used by Health Plans/Insurers When Designing Prior Authorization Programs



Source: AHIP, 2019; California Health Benefits Review Program, 2023.

Note: Percentages indicate the proportion of health plans/insurers that responded they use the evidence-based resource listed.

risk arrangement” by Risk Bearing Organizations (RBOs) and adds complexity for consumers and policymakers. For example, financial risk is shared between the health plan/insurer (i.e., payment for coverage of services) and the enrollee (i.e., cost sharing and premiums), between the employers or consumers who purchase plans via premiums with the insurance company, and between the health plan/insurer and groups of health care professionals that deliver medical services to patients. Medical groups often establish their own requirements for prior authorization that are separate from those of the insurer. As a result, prior authorization policies vary, not only between plans/insurers, but also may vary based on the provider’s location. Prior authorization policies may also differ depending on whether the request is for a prescription drug or for a medical service. In CHBRP’s survey of state-regulated health plans/insurers, responding plans reported just over half of commercial enrollees have health insurance in which no risk is delegated. Nearly 20% of commercial enrollees have health insurance that delegates between 51% and 100% of their risk to an RBO. Additional information about delegated risk is included in Appendix A.

Relevant California Laws and Regulations

In 2015, California passed Senate Bill (SB) 282 in an effort to streamline the prior authorization process. SB 282 required Department of Managed Health Care (DMHC) and California Department of Insurance (CDI) to develop a uniform form for prior authorization for use of prescription drugs prior to January 1, 2017, and authorized the use of electronic prior authorization. The law also requires prescribing health professionals to use, and DMHC-regulated health plans and CDI-regulated health insurers to accept only the forms developed by DMHC and CDI or the electronic process as of July 1, 2017. Finally, the law states that a prior authorization request for a prescription medication will be deemed granted if a DMHC-regulated health plan or CDI-regulated health insurers fails to respond to a request within 72 hours for nonurgent requests, and within 24 hours under exigent circumstances.⁸ Urgent care appointments for services that require prior authorization must be made available within 96 hours of the request.⁹

Existing law also prohibits DMHC-regulated health plans and CDI-regulated health insurers from using their own clinical criteria to make medical necessity decisions¹⁰ related to mental health and substance use disorders. SB 855 (2020) expands on the California Mental Health Parity Act, requiring that grandfathered and nongrandfathered DMHC-regulated health plans and CDI-regulated policies use clinical criteria and guidelines consistent with generally accepted standards of mental health and substance use disorder care developed by nonprofit professional associations when conducting utilization review for medical necessity of care and services related to mental health and substance use disorders.¹¹

Average Processing Time of Requests

The length of time from submission of an initial request to a final decision may vary significantly depending on the circumstances of the request. As mentioned previously, some prior authorization requests require modifications or peer-to-peer review that must happen prior to the health plan/insurer making a final decision; these additional steps would increase the total time necessary for receipt of a final response. The results of the CHBRP survey of state-regulated health plans/insurers found that, in general, the length of time to complete an electronic prior authorization request for the medical benefit in 2022 is shorter than it was in 2019 and comparatively longer for requests under the pharmacy benefit. The average length of time for a single manual prior authorization for both medical and pharmacy benefits generally increased in 2022 compared to 2019 (Table 1).

⁸ HSC 1367.24 and 1367.241; INS 10123.191.

⁹ HSC 1367.03(a)(5); INS 10133.54(b)(5).

¹⁰ For more information on medical necessity determinations, please see CHBRP’s issue brief *Medical Necessity Determination Process for Covered Benefits*, available at www.chbrp.org.

¹¹ HSC 1374.721; INS 10144.52.

Table 1. Average Length of Time for Single Prior Authorization Request

	Medical Benefit		Pharmacy Benefit	
	2019	2022	2019	2022
Electronic prior authorization*	46-124 hours	12-46 hours	20-58 hours	31-69 hours
Manual prior authorization (i.e., phone, mail, fax)	70-125 hours	100-120 hours	23-44 hours	30.5-55 hours

Source: California Health Benefits Review Program, 2023.

Notes: 1) Average length of time is measured from time of initial request to final response from health plan/insurer.

2) The results are based on responses from CHBRP survey of the largest (by enrollment) commercial DMHC-regulated health plans and CDI-regulated insurers, excluding DMHC-regulated Medi-Cal.

3) Table results represent the total range of responses from health plans/insurers, not the average length of time across all health plans/insurers.

*Some plans/insurers indicated in their responses that they first implemented electronic prior authorization in 2019.

WHY IS PRIOR AUTHORIZATION USED?

There are varying definitions and reasons for using prior authorization. One common theme is the aim to reduce and control health care spending. For example, the Centers for Medicare & Medicaid Services (CMS) states the intent of the prior authorization process is to control unnecessary increases in the volume of services, and assist suppliers in ensuring their services comply with applicable Medicare coverage, coding, and payment rules prior to services being rendered or items being delivered (CMS, 2023). This section provides context related to the use of prior authorization, including current spending and background on excess spending and fraud and waste within the health care system.

Trends in U.S. Health Care Spending

Total national health expenditures as a share of the gross domestic product (GDP) have increased steadily over time. In 2022, health expenditures accounted for 17.4% of the GDP (Keehan et al., 2023). The increase in health care spending in the United States over the last 2 decades (from 13.3% in 2000) is due to two primary factors: increased utilization of services and increased costs of services. Although changes in the U.S. population may account for some of the increase in utilization (e.g., an increasing number of persons over age 65 years, a higher share of people with chronic conditions), other changes such as increased rates of insurance coverage and an increase in covered benefits also contribute to changes in utilization. Regarding the cost of services, the cost of health care services has typically grown faster than the cost of other goods and services. In the past 20 years, the Consumer Price Index (CPI) has grown at an average of 2.5% per year, while the CPI for medical care has grown at an average of 3.2% per year (Peter G. Peterson Foundation, 2023).

Excess Health Care Spending

As noted above, although the overall increase in health care spending can be largely attributed to increased cost of services and increased utilization, there is another important piece that drives both increased utilization and cost of services. Unnecessary medical care or wasteful health care spending, such as administrative complexities and fraud, are additional drivers. A recent study estimates that between 20% and 25% of all health care spending in the United States is a result of wasteful and unnecessary spending, as well as missed opportunities to provide appropriate care (Shrank et al., 2019). Assuming that these proportions are similar in California, this would equate to between \$58 and \$73 billion in unnecessary health care spending per year (Eibner et al., 2020).

The top six contributors (Eibner et al., 2020; IOM, 2010; Shrank et al., 2019) to wasteful health care spending include:

- Administrative complexities in health care delivery and payment;
- Failures of care coordination;
- Failures of care delivery and inadequate prevention;
- Fraud and abuse;
- Overtreatment or low-value care;
 - Ordering duplicative tests; prescribing treatments with little to no value; ordering high-cost treatment when lower-cost treatments could be as or more effective; and
- Pricing and market inefficiencies, including prices that are too high.

Unnecessary Care

Unnecessary health care can include low-value care, which are medical interventions that provide little to no benefit to the patients, have potential to cause harm, incur unnecessary costs to patients, or waste limited health care resources (V-BID, 2023). According to a 2017 survey of physicians from the American Medical Association (AMA), physicians estimate that 20% of overall medical care is unnecessary, including 22.0% of prescription medications, 24.9% of tests, and 11.1% of procedures (Lyu et al., 2017).

For example, duplicate imaging due to incompatible medical records or lack of data sharing contributes to unnecessary medical care. The top three reasons for overtreatment physicians cited in the study were “fear of malpractice” (84.7%), “patient pressure/request” (59.0%), and “difficulty accessing prior medical records” (38.2%) (Lyu et al., 2017).

Fraud, Waste, and Abuse

The National Health Care Anti-Fraud Association conservatively estimates that approximately 3% of all annual health care spending in the United States (approximately \$300 billion) is lost to fraud (NHCAA, 2023). Health care fraud is a form of white-collar crime that involves filing fraudulent medical claims in order to receive illegal compensation. Health insurance fraud involves a person or company filing false claims to be reimbursed by an insurance provider. The majority of fraud is committed by a small number of individuals (NHCAA, 2023). Fraud and abuse are intentional acts by individuals, whereas waste may be intentional or unintentional. Billing errors are one type of action that may be either intentional (fraud or abuse) or unintentional (waste). Additionally, system inefficiencies may contribute to waste.

Between 2012 and 2019, the federal Medicaid program and Children’s Health Insurance Program (CHIP) experienced a steady increase in improper payments, including underpayment, overpayment, fraud, and unknown payments. The percentage of improper payments rose from approximately 7% and 8% for CHIP and Medicaid, respectively, to approximately 16% and 15% (Kumaraswamy et al., 2022). Similarly, Fiscal Year 2020 estimates from CMS state that approximately 6% of Medicare fee-for-service, 7% of Medicare Part C, 1% of Medicare Part D, 21% of Medicaid, and 27% of CHIP payments were improper payments¹² or improper payment rates (CMS, 2020). “A significant amount of improper payments is due to instances where a lack of documentation or errors in the documentation limits CMS’s ability to verify the payment was paid correctly. However, had the documentation been submitted or properly maintained, then the payments might have been determined to be proper. A smaller proportion of improper payments are payments that should not have been made or should have been made in different amounts and are considered a monetary loss to the government (e.g., medical necessity, incorrect coding, beneficiary ineligible for program or service, and other errors)” (CMS, 2020).

Fraud within California’s state-regulated health plans and policies

Health plans/insurers operating in California responding to CHBRP’s query on areas of highest fraud and abuse noted that waste and abuse may occur more frequently when low-value or medically unnecessary care is delivered. More specifically, behavioral health – particularly applied behavioral analysis – was identified by health plans/insurers as a leading fraud risk under the medical benefit. In 2021, the U.S. Department of Health and Human Services Office of Inspector General published a report pointing to weaknesses in the evaluation of, and oversight for, telehealth services – a manner in which many behavioral health services are provided – as a potential source of fraud and abuse (OIG, 2021).

State-regulated health plans/insurers also report fraud for services and medications provided under the pharmacy benefit. Responding health plans/insurers described accounts of falsification of prior authorizations, inappropriate billing practices, and provision of unnecessary (and unrequested by patients) billable products by certain entities, including pharmacies and telehealth entrepreneurs. Two areas identified by health plans/insurers in the CHBRP survey where this occurs the most for prescription drugs are: 1) drugs and products deemed preventive, where cost sharing and prior authorization is prohibited; and 2) controlled substances, including stimulant drugs where adequate time and measures have not been taken to qualify utilizers of the controlled stimulant drugs. Specific examples provided by survey respondents include dermatological agents, such as those for rheumatoid arthritis, psoriasis, and atopic dermatitis, and immunological agents, such as those for inflammatory bowel disease. Survey results also highlighted concerns around antiobesity drugs, blood glucose regulators, and insulin.

¹² Improper payments are payments that did not meet statutory, regulatory, administrative, or other legally applicable requirements and may be overpayments or underpayments. Additionally, improper payments do not necessarily represent expenses that should not have occurred.

IMPACTS OF PRIOR AUTHORIZATION

This section provides an overview of the impact of prior authorization on patient safety, access to and utilization health care services, health outcomes, reductions in fraud and waste, and patient and provider experiences with prior authorization.

The peer-reviewed literature base evaluating the impact of prior authorization is relatively limited. Much of the published literature regarding the impact of prior authorization focuses on prescription medications. Additionally, prior authorization is commonly grouped together with other utilization management techniques, such as step therapy, preferred/nonpreferred medication lists, and cost sharing. Overall, the evidence regarding whether prior authorization improves patient safety and health outcomes, reduces excess spending, and ensures medically appropriate care is provided, is mixed. However, there is a clear consensus from patients and providers that there are substantial challenges when health insurers implement prior authorization requirements for covered benefits.

Patient Safety

There is some evidence, limited to prescription medications, that demonstrates prior authorization can improve patient safety. Three studies from 2012 and 2013 found that prior authorization reduced the use of contraindicated medications and that prior authorization reduced use of medications among patients for whom the medication could have resulted in harm (Gleason et al., 2013; Ross et al., 2012; Starner et al., 2012). However, these studies were of a small number of patients, limiting the generalizability of these findings to other types of patients and other conditions/treatments. Additional information on these studies is included in Appendix C.

Access to Health Care Services

According to a national survey published by the Kaiser Family Foundation in June 2023, approximately one in six insured adults (16%) state their health insurance denied or delayed prior authorization for necessary care within the previous 12 months. These issues were experienced by about one in five (22%) Medicaid beneficiaries in comparison to about one in ten (11%) of Medicare beneficiaries (Pollitz et al., 2023). Several studies have also found that prior authorization results in delays in care, either due to an initial denial and the appeals process, or because of the additional work and time required to complete the initial prior authorization request.

Denials and appeals

Within the studies described in this section, several provided information about initial denials, appeals, and subsequent approvals after initial prior authorization requests were submitted. Across studies, a sizable share of prior authorization denials were overturned upon appeal, ranging from 40% to 82% of denials being overturned. The reasons for the initial denial were mostly due to submission of incomplete clinical data or insufficient documentation of medical necessity.

A study among patients whose in-office lower extremity superficial venous procedures were subject to prior authorization, 6% of the claims were initially denied (Lee et al., 2020). Nearly 40% of the denials were overturned upon appeal. Among patients with complex dermatologic conditions for whom a prior authorization request was made, approximately half of the requests were initially denied, with systemic medications more likely to be denied than topical medications (Jew et al., 2020); 69% of all requests were ultimately approved. Wallace et al.'s 2020 study on the impact of prior authorization on outcomes among patients who were prescribed infusion medications found that 71% of the patients required prior authorization for the infusion medications, and 20% of these requests were initially denied. Upon appeal, 82% of the denials were approved, with most requiring peer-to-peer discussions.

Recent audits from the U.S. Office of Inspector General of Health and Human Services evaluated denial rates among Medicare Advantage Organizations and Medicaid Managed Care plans. On average, Medicaid Managed Care plans denied 12.5% of prior authorization requests, but the denial rates among plans varied widely, with a low of 2% and up to a high of 34% (OIG, 2023). Of the prior authorization requests denied by Medicare Advantage Organizations, 13% met Medicare coverage rules and would have likely been approved for these beneficiaries under original Medicare (i.e., Medicare fee-for-service) (OIG, 2022). Another analysis found that among the 11% of Medicare Advantage denials of prior authorization, 82% of appeals resulted in fully or partially overturning the initial denial (Fuglesten Biniek and Sroczynski, 2023).

Time to care

A systematic review by Ismail et al. (2023) examined the effects of prior authorization on treatment delay and utilization of specialty drugs. Nine studies found that prior authorization requirements created delays in treatment. Several studies reported that prior authorization increased time to treatment initiation, ranging from 3.6 days for cancer drugs to up to 31 days for rheumatoid arthritis and inflammatory bowel disease biologics (Agarwal et al., 2017; Constant et al., 2022; Wallace et al., 2020). More research is needed to examine the effect of prior authorization on long-term health outcomes (Ismail et al., 2023).

Utilization of Health Care Services Subject to Prior Authorization

Prescription Medications

There is a substantial amount of literature examining the impact prior authorization has on the utilization of medications subject to prior authorization. Generally, evidence shows that prior authorization requirements result in lower utilization of the medication subject to prior authorization. However, studies have also shown that prior authorization decreases medication adherence.

Two systematic reviews examined whether prior authorization had a positive (lower utilization),¹³ negative (higher utilization), or neutral impact on the utilization of prescription medications (Happe et al., 2014; Park et al., 2017). Happe et al. found that prior authorization's impact on medication adherence was neutral in two studies, had negative impacts in two studies, and had a positive impact in one study. Park et al.'s similarly conducted literature review found prior authorization's impact on medication adherence was neutral in one study, negative in four studies, and was positive in one study. When looking specifically at utilization of medications, prior authorization overwhelmingly (16/19 outcomes) had a positive impact, meaning lower utilization of the medication. Another systematic review examining the effects of prior authorization on utilization of specialty medications found that prior authorization policies had mixed effects on utilization of the medications (Ismail et al., 2023).

In the case of prescription opioids, four studies identified through Mauri et al.'s 2020 systematic review demonstrated that short-acting opioids were substituted for long-acting opioids as a response to the prior authorization policies, yielding no statistically significant change in overall use of prescription opioids, but instead changing the type of opioids prescribed (Barnett et al., 2018; Hartung et al., 2018; Keast et al., 2018; Morden et al., 2008). For example, Morden et al. (2008) examined Medicaid prescription claims to compare states whose Medicaid programs had strict, lenient, or no prior authorization for controlled-release oxycodone. Strict prior authorization was associated with a 34% reduction in oxycodone use and lenient prior authorization was associated with a nonsignificant increase of 6% in use.

For buprenorphine, Andrews et al. (2019) found reduced availability of the drug in states in which Medicaid required prior authorization, and Mark et al. (2020) found that removal of prior authorization for Medicare beneficiaries doubled the number of prescriptions. A third study compared the impacts of removal of prior authorization requirements in the Medicaid programs of Illinois and California (Keshwani

¹³ Naming conventions used in the CHBRP report reflect those used in the studies cited.

et al., 2022). The authors observed an immediate, non-statistically significant increase in the number of all buprenorphine prescriptions for opioid use disorder and a statistically significant decrease in prescriptions over time after the removal in California. By contrast, a statistically significant increase in prescriptions was seen immediately and over time in Illinois upon changes to their prior authorization requirements. The authors note the differences could be explained by factors outside of prior authorization processes, such as differences in utilization trends and other terms and conditions.

Ferries et al. (2021) examined the impact of the removal of prior authorization for medication-assisted treatment and found an almost 8% increase in initiation of medication-assisted treatment.

Interaction with other benefit designs

Study findings suggest that prior authorization interacts with other policies and programs that health plans implement to constrain utilization and cost. Ozaki et al. (2021) looked at the impacts of cost sharing and prior authorization on utilization of prescription medications for chronic heart failure. The results showed that despite commercial plans having stricter prior authorization requirements, utilization of the drugs was four times higher by enrollees in commercial plans than they were for Medicare; the authors hypothesize the higher copayments and other factors may contribute to difference in utilization behaviors. Other studies have also found confounding impacts of other utilization management policies, making it challenging to determine the impact of prior authorization specifically.

In Gleason et al.'s 2013 study, although there was no statistical difference in the users of dalfampridine per 100,000 members, the average claims per member were double in the control group as compared with the group with prior authorization (4.2 vs. 2.1 claims per member). The control group has substantially higher cost sharing for the medication (\$667 vs. \$138). The authors suggested that benefit designs involving high cost sharing were not as effective as the prior authorization program in ensuring that individuals at minimal risk for adverse event who met clinical criteria are utilizing dalfampridine.

The combined results of these studies indicate that although the practice of prior authorization itself may have a significant impact on utilization of specific prescription medications, policymakers should also consider other policies that may impact utilization and uptake of the drug.

Utilization of Other Health Care Services

Health Care Services

The evidence regarding the impact of prior authorization on the use of other health care services is mixed. Whereas some studies have found prior authorization reduces emergency department visits and hospitalizations, others have found an increase in other health care services.

The Happe et al. (2014) and Park et al. (2017) literature reviews also examined the impact of prior authorization for medications on the use of other health care services, such as outpatient visits, emergency department visits, and hospitalizations. Happe et al. found that for 13 outcomes, there was a neutral impact of prior authorization, for 2 outcomes there was a negative impact (the group with prior authorization had higher emergency department utilization in both studies), and for 2 outcomes, there was a positive impact (within the same study examining the impact of prior authorization for antipsychotic medications, the group with prior authorization had lower utilization of emergency department visits and office visits). Park et al. found that 1 outcome of other health care resource utilization was neutral, 8 outcomes were negative, and 5 outcomes were positive.

A 2022 study that examined the impact of prior authorization for repetitive, scheduled, nonemergency ambulance transport (RSNAT) services found that Medicare beneficiaries required to go through prior authorization were not more likely to use emergency transportation services and had a smaller probability of emergency department use and unplanned hospital admissions. The results did show a decrease in

scheduled dialysis (1% of baseline), suggesting the possibility of limited delay of care and an increase in unscheduled dialysis visits, approximately 19% higher than baseline; no adverse outcomes, such as hospitalizations were noted.

Prescription Medications

For the impacts of prior authorization on utilization of other medications, evidence points to a shift in utilization from medications with prior authorization requirements to medications without prior authorization requirements.

Two studies within Mishuk et al.'s 2020 systematic review found that prior authorization was an effective policy in increasing the use of generic nonsteroidal anti-inflammatory drugs (NSAIDs) and generic antidepressants, antidiabetic agents, and statins.

Findings from three studies included in CHBRP's analysis of Assembly Bill 2144 (2020) found that prior authorization for pregabalin was associated with an increase in prescriptions for other medications. Some of these prescriptions were for other anticonvulsant medications that may have similar risks and benefits, whereas others were for opioids, which have greater risks of misuse and overdose. Similarly, a systematic review examining the effectiveness of prior authorization for pregabalin (Lyrica) found that prior authorization led to a shift toward use of other prescription medications, including prescription opioids (Stacey et al., 2017).

A 2021 study (Ferries et al.) examining the impact of the removal of prior authorization for medication-assisted treatment on opioid use found the policy change led to a decrease in opioid utilization.

Health Outcomes

Outcomes related to medication use

The evidence examining health outcomes as a result of prior authorization policies is limited. While there are a few studies that demonstrate clear negative impacts of prior authorization, others demonstrate clear positive impacts. The evidence overall is mixed, making it challenging to determine whether prior authorization has an impact on health outcomes.

Happe et al. (2014)'s review found that prior authorization had a positive impact on quality of life for the single study that included this outcome. Within Park et al.'s 2017 review, prior authorization resulted in negative clinical outcomes among the four studies that included clinical outcomes. For example, Accurso and Rastegar (2016) found that a decrease in buprenorphine dose due to prior authorization was associated with an increase in drug test results outside of the normal range. Several other studies also included the impact on clinical outcomes, but the findings were either unstable or not statistically significant.

Ferries et al.'s 2021 examination of the impact of the removal of prior authorization for medication-assisted treatment found that among the patient population who initiated treatment after the removal, there was a 19% decrease in likelihood of relapse, and among those who were confirmed as diagnosed with an opioid use disorder prior to beginning the treatment, 47% were less likely to relapse. In another study, Cochran et al. (2017) examined the impact of prior authorization on rates of opioid medication abuse and overdoses. The study found that compared to people enrolled in plans with no prior authorization, enrollees in both high prior authorization (prior authorization required for many opioids) and low prior authorization plans (prior authorization required for one opioid medication) had significantly lower rates of opioid abuse. Enrollees in the low prior authorization plan had significantly lower rates of overdose than enrollees in plans with no prior authorization. People enrolled in the high prior authorization plans also were less likely to overdose, but the difference was not statistically significant.

Reducing Excess Spending, Including Waste and Fraud

Of the studies that evaluated the impact of prior authorization, the impact on economic outcomes was frequently reported. Studies generally found that the impact of prior authorization on spending related to the medication or service subject to prior authorization was lower, whereas the impact on other health expenditures or total expenditures was mixed.

Happe et al. found that prior authorization's impact on economic outcomes was positive for 5 outcomes, negative for 4 outcomes, and neutral for 7 outcomes. Outcomes included total pharmacy costs, medical costs, and cost per treatment, and the impact on the outcome was dependent upon the disease and medication type. In Park et al.'s literature review, the majority of the positive outcomes were for the impact of prior authorization on pharmacy costs (meaning pharmacy costs were lower), whereas the majority of the negative outcomes were for the impact of prior authorization on medical costs (meaning overall medical costs were higher).

Of the above described articles, several concluded that prior authorization reduced expenditures (Contreary et al., 2022; Gleason et al., 2013; Mishuk et al., 2020), while one found the administrative costs of prior authorization outweighed the savings due to decreased utilization (Lee et al., 2020).

A few plans provided information about estimated savings generated by prior authorization programs. CHBRP requested information from 2019 and for 2022, broken out by manual and electronic PA. Although not generalizable because of the limited responses to this question, CHBRP found that reported savings increased between 2019 and 2022, and the use of electronic prior authorization vs manual prior authorization increased.

Patient and Provider Experiences With Prior Authorization

There is clear frustration from both patients and providers regarding prior authorization. Complaints range from the time required to complete the initial prior authorization request and pursue denials, to delays in care, to a general lack of transparency regarding the process and criteria insurers use to evaluate prior authorization requests.

Patient Experiences

Patients have reported challenges with gaining approval for services that require prior authorization, burdensome paperwork requirements, and delays in access to care (Navar et al., 2017).

A recent survey of insured patients ages 18 through 64 years regarding administrative burden found 21% of patients reported spending time on prior authorization requests in 2019 (Kyle and Frakt, 2021). Among all patients, approximately 8% reported that prior authorization resulted in administrative burden, 7% reported a delay in care, and 5% reported forgoing care. People with disabilities, younger patients, those identifying as African American, and people with lower incomes were more likely to report experiencing administrative burdens.

Blake et al. (2019) noted that prior authorization requirements, among other factors, created barriers to treatment continuity and quality for youth with attention-deficit/hyperactivity disorder (ADHD) and led to more administrative burden for safety-net clinics serving these youth. "When a recommended psychosocial service requires prior authorization and has not yet been authorized (either due to the length of time of the prior authorization process or a denial of the prior authorization request), this creates a disconnect between the psychosocial service the clinician has recommended and the services that can be received by the child" (Blake et al., 2019).

Provider Experiences

Prior authorization can also pose challenges and create frustrations for providers. Many providers view prior authorization as an additional cost and time burden on office staff (Soni and Hertler, 2023) as well on clinician time. Many aspects of prior authorization workflow still rely on the resource-intensive use of paper forms, telephone calls, facsimile communications, and portal access. Contributing to the resource-intensive process is the type of technology (or lack of) used by providers and plans. Although many providers have transitioned to electronic health records, for some providers, the cost to do so is prohibitive (AHIP, 2022b). Additionally, not all electronic health records easily communicate with other electronic health records, thereby still requiring a person to manually transfer information from one system to another.

According to the 2020 CAQH Index,¹⁴ providers across the United States reported spending an average of 20 minutes on manual prior authorization requests, 13 minutes via a web portal, and 8 minutes when using a fully electronic, HIPAA-mandated standard (CAQH, 2021). In another study, Jew et al. (2020) reported that providers spent a median time of 30 minutes per prior authorization request on administrative work. A 2022 survey from the American Medical Association found that 35% of physicians surveyed reported they have staffers who work exclusively on prior authorization (AMA, 2023). Almost 9 out of 10 of these physicians describe the burden associated with prior authorization as “high” or “extremely high.” More than half (56%) of surveyed physicians also say prior authorization “often” or “always” delays access to necessary care.

Similarly, almost 94% of respondents to a 2021 survey among American College of Gastroenterology members perceived a high or extremely high burden of prior authorization requests (Shah et al., 2022). Respondents reported receiving a median of 10 prior authorizations in the previous 7 days and 2 written appeals or telephone peer-to-peer requests. Almost half of the prior authorization requests and appeals within the previous 7 days were related to refill requests for a medication the patient was already taking. Providers reported avoided talking about a preferred medication with a patient because of a high perceived likelihood of a coverage denial (58%) and encouraging patients to contact their insurer directly when pursuing prescription medication approval, in addition to or in lieu of the provider’s office contacting the insurer on the patient’s behalf (68%). Additionally, more than half (54%) of respondents reported that at least one of their patients suffered a serious adverse event (e.g., death, hospitalization, disability/permanent bodily damage, or other life-threatening event) due to delays in care delivery attributed to the prior authorization process.

In some cases, external organizations may provide assistance with completing necessary prior authorizations. A qualitative study examining the ability of health care providers to deliver hereditary testing to patients compared the experiences of providers in academic medical centers (AMCs), which generally work with commercial insurance and Medicare, to those of providers in public clinics, which generally work with Medicaid (Lin et al., 2022). Genetic testing is commonly performed at internal labs at AMCs, and therefore the prior authorization paperwork was completed by the ordering provider. For providers at public clinics, which send the genetic material to an external lab for testing, the lab is either a Medicaid-contracted lab or provides assistance with completing the prior authorization paperwork. Providers at AMCs noted how the prior authorization process was cumbersome and required multiple interactions, whereas the providers at public clinics noted the relative ease of obtaining prior authorization due to the specialized assistance from the labs. However, respondents from both AMCs and safety-net clinics expressed frustration about the lack of insurance personnel with genetics expertise, which further complicated efforts to obtain prior authorization.

¹⁴ The CAQH Index is the industry source for tracking health plan and provider adoption of fully electronic administrative transactions and the opportunity for future savings. The annual report produced by CAQH measures national progress in reducing the U.S. healthcare industry’s costs and burden associated with administrative transactions.

PRIOR AUTHORIZATION AND PUBLICLY FUNDED INSURANCE

Prior authorization requirements differ for publicly funded programs, including Medicare, Medicare Advantage, and Medi-Cal.

Medicare

Traditional Medicare

Medicare Part A and Part B¹⁵ rarely require prior authorization. Traditional Medicare requires prior authorization for a limited number of services, including durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS); repetitive, scheduled, nonemergent ambulance transport (RSNAT); certain hospital outpatient department services; and MRIs.¹⁶ All traditional Medicare prior authorization requests must be approved prior to rendering of services. In Medicare Part D, in which private insurers administer the prescription medication benefit, approximately one in four medications on the plans' formularies is subject to prior authorization requirements (MedPAC, 2019).

Medicare Advantage

Medicare beneficiaries may choose to receive their Part A, Part B, and Part D benefits through a private Medicare Advantage (MA) plan. MA plans are administered by private insurers that contract with the federal government and must meet federal standards. An analysis by the Kaiser Family Foundation (KFF) found that nearly all (99%) MA enrollees are in plans that required prior authorization for some services in 2022. KFF found that prior authorization was most often required for high-cost services, including durable medical equipment (99%), Part B drugs (99%), skilled nursing facility stays (98%), and acute (98%) and psychiatric (94%) inpatient hospital stays. A total of 6% of MA enrollees were required to receive prior authorization for preventive services (KFF, 2022).

A 2021 study measured the extent of prior authorization and found that approximately 41% of enrollees in traditional Medicare Part B received at least 1 service per year that would have been subject to prior authorization, had the enrollee been in a Medicare Advantage plan (Schwartz et al., 2021). Enrollees received an average of 2.2 services annually per enrollee. These services accounted for approximately 25% of total Medicare Part B spending. The majority of the spending was for Part B medications and injectable medications, which are often provider-administered and delivered in an office or hospital setting (e.g., oncology medications). On average, more than half (56%) of clinicians performed 1 or more prior authorization service per year for sampled Medicare beneficiaries. The highest rates were observed in radiation oncology (97% of clinicians), cardiology (93%), diagnostic radiology (91%), neurosurgery (90%), hematology or oncology (88%), and rheumatology (85%). The lowest rates were observed in pathology (2%), psychiatry (4%), and dermatology (12%).

¹⁵ Medicare Part A hospital insurance covers inpatient hospital care, skilled nursing facility, hospice, lab tests, surgery, home health care. Medicare Part B covers medical services such as doctors' services, outpatient care, and other medical services not covered by Part A.

¹⁶ After July 1, 2023, prior authorization will be required for the following hospital outpatient department services: blepharoplasty, botulinum toxin injections, panniculectomy, rhinoplasty, vein ablation, implanted spinal neurostimulators, cervical fusion with disc removal, and facet joint interventions (CMS, 2023).

Medi-Cal

Authorization requirements for Medi-Cal services are based on Federal and State law, and differ based on whether the service, test, or treatment requested is on the medical or pharmacy benefit.¹⁷ For tests, treatments, and services under the medical benefit, DHCS employs utilization management practices, including prior authorization, to ensure that all benefits or services are medically appropriate for the beneficiary based upon authorization requests that are known as “Treatment Authorization Requests (TARs)” (DHCS, 2021). Authorization requests under the pharmacy benefit are referred to as prior authorization requests.

Medical Benefit

TARs are required for any requested noncovered services (services only covered when medically necessary and after approval of the TAR), for treatments provided by certain primary surgeons/providers or assistant surgeons, and for some inpatient hospital stays (examples of noncovered services include biomarker testing for oncology and acne removal via surgery).¹⁸ In general, providers must request authorization prior to rendering the service.¹⁹

Pharmacy Benefit

For tests, treatments, and services under the pharmacy benefit, prior authorization requests are handled by DHCS through the Medi-Cal Rx program. The program became operational on January 1, 2022, as part of an executive order to transition all Medi-Cal pharmacy services from managed care to fee-for-service. During the transition, DHCS implemented a policy to ensure that Medi-Cal beneficiaries with existing prescriptions, with or without approved prior authorizations, would have continued coverage for covered Medi-Cal pharmacy benefits. The policy included a 180-day period in which DHCS did not require prior authorization for certain prescriptions. Beginning in July 2022, DHCS began a phased approach to restore select prior authorization requirements by therapeutic drug class. As of June 23, 2023, DHCS had completed three of four phases of the reinstatement process for prior authorizations.

For certain drug categories, Medi-Cal Rx prior authorization requests are first processed for medical necessity requirements using historical data already known to the program. If the medical necessity requirements are met in this step, then no additional review is necessary, and the request is approved. Requests for other drugs are evaluated by certified pharmacy technicians, nurses, and pharmacists to review documentation, eligibility, and program coverage. Decisions on requests are made based on medical necessity using supporting documentation, clinical documentation, evaluation of evidence-based medicine and clinical best practices. Medi-Cal providers receive a response regarding a prior authorization request within 24 hours of DHCS’ receipt of the request, per state law.²⁰ Requests may be approved, deferred (i.e., require additional information), or denied. Denials and modified approvals may be appealed through the Medi-Cal Rx beneficiary appeals process.

¹⁷ All outpatient prescription drugs are covered on a fee-for-service basis for all Medi-Cal beneficiaries under a program called Medi-Cal Rx. The Medi-Cal pharmacy benefit is “carved out” of the coverage provided by DMHC-regulated Medi-Cal plans.

¹⁸ For more details, see TAR and Non-Benefit: Introduction to List. Available at: <https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/tarandnon.pdf>.

¹⁹ For a complete list of all medical services that require a TAR under Medi-Cal, may be found in the Medi-Cal provider manual, Part 2 – General Medicine, and Part 2 – Clinics and Hospitals. Available at: <https://mcweb.apps.prd.cammis.medi-cal.ca.gov/publications/manual>, and <https://mcweb.apps.prd.cammis.medi-cal.ca.gov/publications/manual>, respectively.

²⁰ Welfare and Institutions Code 14133.37.

BENEFITS MANAGEMENT IN CALIFORNIA-REGULATED INSURANCE: FINDINGS FROM A CHBRP SURVEY

This section provides information on prior authorization collected from a 2023 CHBRP survey of the largest (by enrollment) providers of health insurance in California. CHBRP requested information regarding prior authorization practices for tests, treatments, and services under both the medical and pharmacy benefits. Responses to the medical and pharmacy benefit surveys represent 73% of enrollees with commercial DMHC-regulated health plans and CDI-regulated health policies. CHBRP found virtually no self-reported differences between Administrative Services Only/Self-Insured lines of business and state-regulated policies, in terms of self-reported characteristics of prior authorization programs. National data is included, when possible, to provide additional context.

Responses on trends related to prior authorization requests show high variability among health plans/insurers. The latter may be due to a number of factors, such as differences in the needs of their respective enrollee populations, variations in plan/insurer priorities on prior authorization at the state and/or national level, or contractual differences with risk-bearing organizations, among other possible reasons. The results of the survey show there is some consistency among health plans/insurers regarding their internal review processes.

Internal Review Processes

Determination of Prior Authorization List

In general, state-regulated health plans and insurers use internal working groups or committees to determine which medical services and prescription drugs will be on their prior authorization lists. Multiple factors are reviewed for each service or drug, such as utilization rates, safety issues and/or recalls, clinical efficacy and variance, cost, historical rates of fraud/abuse/waste, availability of clinically sound alternatives, administrative burden, historical prior authorization approval rates, and potential delays to patient care if prior authorization requirements were to be added. Throughout this review process, codes for medical services and prescription drugs are either added or removed from the lists.²¹ Plans/insurers reported that the primary goals of prior authorization are to facilitate coverage of evidence-based medically necessary care, and that care is covered at the appropriate level of care and in the appropriate setting.

Review of Prior Authorization List

Health plans and insurers generally update or amend their requirements and protocols based on the introduction of new treatments and medical guidelines, as appropriate. A 2022 nationwide survey by AHIP, found that 96% and 100% of all responding plans review their prior authorization lists for medical services and prescription drugs, respectively, at least annually (AHIP, 2022b). The remaining 4% of medical services for responding plans are reviewed every 2-3 years. The survey included responses of 26 nationwide health plans covering 122 million commercial enrollees (AHIP, 2022b).

In comparison, based on CHBRP's survey for this report, 100% of all responding California health plans/insurers review their prior authorization requirements for both medical services and prescription drugs at least once annually. Survey respondents noted that Utilization Management Committees met periodically during the year or semiannually to review their prior authorization lists along with any requests to delete or add services. Over 25% of commercial enrollees have coverage in a plan/policy that reviews prior authorization lists on a more frequent basis (i.e., between quarterly and twice a year). The frequency at which the prior authorization lists change, however, varies by health plan/insurer. Some

²¹ It should be noted that other external factors, including state and federal laws and regulations and contract updates may also impact the frequency at which prior authorization lists are reconsidered.

health plans/insurers have very stable prior authorization lists, with few to no changes per review; whereas others make substantial updates to their prior authorization lists during reviews.

Factors taken into consideration prior to adding a new service code to prior authorization lists include services that meet one or more of the following criteria:

- Services associated with known safety issues and/or recalls;
- Services prone to overutilization (i.e., waste) and/or abuse;
- Rarely performed services;
- Services determined to be experimental/investigational/unproven based upon available clinical evidence;
- High-cost services; and
- Unlisted service codes that can be used to represent a variety of different health care services.

Validity Period of Authorization

CHBRP found, based on its survey results, that most prior authorization approvals remain valid for approximately 6 months or more before requiring recertification/approval. Responses ranged from 4 to 6 months to 12 to 24 months.

CHBRP requested information from plans/insurers on whether prior authorization approvals for chronic or long-term conditions remain valid for longer periods of time. Plans either did not provide responses to this question or did not specifically have a policy separated out for these conditions.

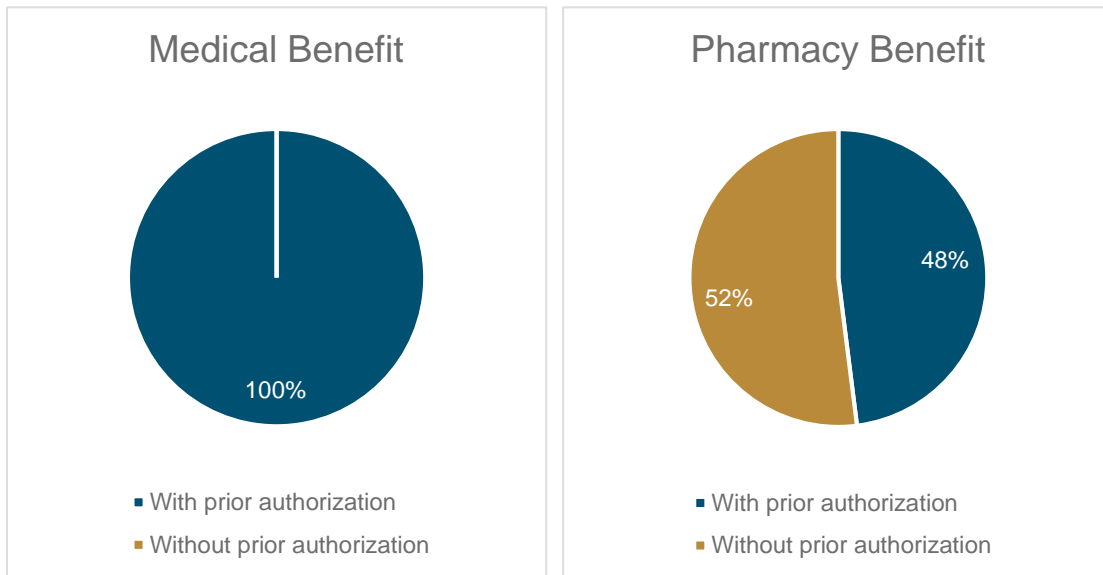
Transparency

CHBRP asked plans/insurers whether their medical-based guidelines for prior authorization are available to the public, providing a level of transparency to patients and providers. Plans/insurers reported that they are generally available to the public.

Enrollees in Health Plans/Policies With Prior Authorization Requirements

Among enrollees with commercial state-regulated health insurance, prior authorization is used for at least some services under the medical benefit for approximately 13.4 million California enrollees (100% of enrollees), and some medications under the pharmacy benefit for approximately 6.5 million California enrollees (48% of those with a pharmacy benefit) (Figure 2). This represents those who have commercial insurance regulated by DMHC and CDI, and excludes those with CalPERS health insurance and Medi-Cal beneficiaries enrolled in DMHC-regulated plans or County Organized Health Systems (COHS).

Figure 2. Share of Enrollees With Commercial State-Regulated Health Insurance That Requires Any Prior Authorization



Source: California Health Benefits Review Program, 2023.

Note: Figures represent the share of enrollees with commercial health insurance that requires or does not require prior authorization.

Benefits Subject to Prior Authorization

Overall, plans reported that between 5% and 15% of all covered medical services were subject to prior authorization requirements, along with between 16% and 25% of pharmacy services (Table 2). Under the medical benefit, services subject to prior authorization accounted for between 7% and 23% of total health plan/insurer expenditures and between 5% and 12% of total utilization of medical services.

Table 2. Percentage of Total Covered Benefits Offered by State-Regulated Health Plans/Insurers Requiring Prior Authorization

Measurement	Medical Services	Pharmacy
% of all covered services	5%-15%	16%-25%
% of total expenditures	7%-23%	*
% utilization	5%-12%	*

Source: California Health Benefits Review Program, 2023.

Note: *Insufficient data collected in survey.

Table results represent the total range of responses from health plans/insurers, not the average percentage across all health plans/insurers.

Nationally, common services and treatments that require prior authorization for benefit coverage include genetic testing (100% of health plan respondents), specialty drugs (100%), high-cost nonspecialty drugs (88%), elective inpatient surgical procedures (92%), advanced/high-tech imaging (88%), durable medical equipment (80%), orthopedics (80%), and cardiology (80%), (AHIP, 2022b). Mental health services were not identified in this survey.

CHBRP found similar results in California, with some indications of more lower-cost services – such as nonemergency transportation and behavioral health services – being subject to prior authorization. It should be noted, however, there were significant differences among plans for the types of tests, treatments, and services requiring prior authorization.

CHBRP’s survey queried health plans/insurers about specific aspects of prior authorization requests received, including the most frequently requested services, the most costly, and a measurement of how well requests aligned with treatment guidelines. Results provided in Tables 3-5 are self-reported by the health plans/insurers and listed separately for the medical and pharmacy benefit. Each list is a general approximation of combined responses from health plans/insurers.

Most Frequently Requested

CHBRP received survey responses from health plans and insurers indicating the most frequently requested treatments and services under the medical and pharmacy benefits requiring prior authorization (Table 3). The responses ranged significantly among responding health plans/insurers. Notably, some of the most frequently requested services and treatments were not necessarily the most expensive categories of treatments and services. Many of the services under the medical benefit were those requiring ongoing care, such as behavioral health services and physical, occupational, or speech therapies. Some services and treatments were comparatively rare or more expensive albeit with comparatively low utilization rates.

Another striking observation is the difference in the services reported by each health plan/insurer. For example, various imaging services comprised nearly all of one responder’s most frequently requested services for prior authorization, and they were not listed at all for other responders. This speaks to the unique needs of the enrollee populations of each health plan/insurer. Combined with the variation in risk delegation, market segments, medical practice, adherence to evidence-based treatment, and benefit design, among other factors, this creates challenges in the standardization of the prior authorization process, and may be a reason why it differs significantly between some health plan/insurers. A 2019 AHIP survey also found that using technology – through implementation of electronic prior authorization – and standardizing the process for submitting prior authorization requests are two factors that could reduce variation in prior authorization programs (AHIP, 2019).

Table 3. Most Frequently Requested Services as Reported by Commercial Health Plans/Insurers

Medical Benefit	Pharmacy Benefit
<ul style="list-style-type: none"> • Durable medical equipment • Imaging (i.e., magnetic resonance imaging, computed tomography) • Behavioral health services • Mental health services • Therapy (physical therapy/occupational therapy/speech therapy) • Outpatient surgical procedures • Genetic testing • Home care training, family; per session • Sleep studies • Referral for acupuncture • Referral for pediatrics • Psychological tests and evaluation services • Referral for psychiatry • Referral for neurology • Referral pain management 	<ul style="list-style-type: none"> • Adrenergic medications (nerve stimulants) • Antimigraine agents • Diabetic supplies • Central nervous system (CNS) agents – attention-deficit/hyperactivity disorder (ADHD) • Amphetamines • Antiobesity agents – incretin mimetics • Dermatological agents • Lipid agents • Blood glucose regulators – incretin mimetics • Anti-inflammatory tumor necrosis factor inhibitor • Opioid analgesics • Sleep disorder agents

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| <ul style="list-style-type: none"> • Referral maxillofacial, TMJ syndrome • Referral plastic surgery • Referral cardiology • Referral general surgery • Referral radiation therapy • Evaluation and management of established patient in an office or outpatient location • Gastrointestinal endoscopy • Echocardiography procedures • Referral ophthalmology external • Referral hematology oncology external • Referral rheumatology external • Non-compounded foam sclerotherapy • Referral family practice • Referral psychiatry • Referral dermatology | <ul style="list-style-type: none"> • Immunological agents (for rheumatoid arthritis, psoriasis, atopic dermatitis, inflammatory bowel disease, etc.) • Hematopoietic (blood) agents/modifiers • Sexual disorder agents • Androgenic agents • Anticonvulsants (miscellaneous) • Antineoplastics (cancer drugs) • Gastrointestinal agents • Sodium-glucose co-transport 2 inhibitors (type II diabetes) • Human interleukin 12/23 inhibitors, monoclonal antibody • Ophthalmic agents • CNS agents – botulinum toxin, multiple sclerosis agents • Local anesthetics – topical • Antivirals, HIV-specific • Treatment for ADHD/narcolepsy • Respiratory tract/pulmonary agents • Topical immunosuppressive agents • Cardiovascular agents • Topical antiandrogenic agents (prostate cancer) |
|--|--|

Source: CHBRP, 2023.

Note: Order of services are generally based on the order as reported by health plans/insurers.

Bold indicates 100% response rate by responding health plans/insurers.

Key: TMJ = temporomandibular joint.

Alignment Between Prior Authorization Requests and Medical-Based Guidelines

A 2022 analysis by AHIP found that approximately 10% of physicians within the national data sample provided care inconsistent with evidence-based standards of care, as defined by respective specialty societies (AHIP, 2022a). The rates varied by procedure type, ranging from 7.3% for knee arthroscopy prior to knee replacement surgery to 13% for rate of add-on upper endoscopy during a screening colonoscopy.

As previously discussed, health plans and insurers use medical guidelines as part of the basis for their prior authorization requirements and protocols. CHBRP’s survey also asked health plans/insurers to provide the services and treatments for which they found requests most often did not adhere to medical-based guidelines (Table 4). The results related to the medical benefit included several broad categories of services, such as durable medical equipment and prosthetics/orthotics, various imaging technology, and genetic testing, but also included several referrals for various evaluations and procedures. Results for the pharmacy benefit were also broad, with medications covering a wide range of conditions. Similar to the query on the most frequently requested services, health plan/insurer responses had very little overlap, no overlap across all responding health plans/insurers for services under the medical benefit²² and incretin mimetic agents as the only overlapping medication across all responding health plans/insurers under the pharmacy benefit.

²² There was some overlap between individual health plans/insurers, such as with durable medical equipment and physical therapy. However, most responses for this category had no overlap between responding health plans/insurers.

Table 4. Requests That Most Often Did Not Adhere to Medical-Based Guidelines as Reported by Commercial Health Plans/Insurers

Medical Benefit	Pharmacy Benefit
<ul style="list-style-type: none"> • Imaging (i.e., magnetic resonance imaging, computed tomography, positron emission tomography) • Portable oxygen concentrator rental • DME • Sleep studies • Echocardiography procedures • Genetic testing • Musculoskeletal procedures • Therapy (physical therapy/occupational therapy/speech therapy) • Polysomnography (sleep studies) • Foot inserts and fittings • Continuous glucose monitors and related supplies • Molecular pathology procedures • Referral acupuncture • Referral anesthesia (dental) • Referral pediatric evaluation • Powered pressure – reduced air mattress • Referral oncology evaluation • Referral psychiatry • Referral neurology evaluation • Referral maxillofacial oral surgeon • Referral orthopedics evaluation • Compression stocking 	<ul style="list-style-type: none"> • Antineoplastics (cancer drugs) • Immunological agents • Central nervous system (CNS) agents - attention-deficit/hyperactivity disorder (ADHD) • Antiobesity drugs – incretin mimetic agents • Blood Glucose Regulators - Incretin Mimetic Agents (GLP-1) prescribed off-label • Analgesics – opioid (chronic use of immediate and extended-release formulations) • CNS agents – botulinum toxin • Gastrointestinal agents • Dermatological agents • Cardiovascular agents • Local anesthetics – topical • Diabetic supplies (continuous glucose monitors) • Acne products • Ophthalmic immunomodulators • Anticonvulsants – misc. • Antihyperlipidemics – misc. • Immunosuppressive Agents – topical • Anti-inflammatory Agents – topical • Amphetamines • Insulin • Sodium-glucose co-transporter 2 (SGLT2) inhibitors (type II diabetes)

Source: California Health Benefit Review Program, 2023.

Notes: (1) Order of services are generally based on the order as reported by health plans/insurers.

(2) **Bold** indicates 100% response rate by responding health plans/insurers.

Most Costly

CHBRP received survey responses from health plans and insurers of the costliest medical benefit treatments and procedures in their prior authorization lists, as well as mostly costly prescription drugs (Table 5). Similar to the results of other survey questions, responses ranged among health plans/insurers. Several specific types of organ transplants, surgeries, and injections for various conditions were the costliest services under the medical benefit. The results related to the pharmacy benefits were broader, though several related to treatments for type II diabetes.

Table 5. Most Costly Services Subject to Prior Authorization as Reported by Commercial Health Plans/Insurers

Medical Benefit	Pharmacy Benefit
<ul style="list-style-type: none"> • Clinical research trial – referral • Referral pre-transplant, bone marrow • Therapy (physical therapy/occupational therapy/speech therapy) • Heart transplant • Referral radiation therapy • Referral chemotherapy • Cardiac surgery – noncontracted • Injections, eteplirsen and viltolarsen (Duchenne muscular dystrophy) • Lung double transplant • Injection, idursulfase (Hunter syndrome) • Eating disorder patient • Cardiology (e.g., catheterization, etc.) – noncontracted • Lung transplant with bypass • Psychiatry – noncontracted • Injection, eculizumab (atypical hemolytic uremic syndrome – rare genetic disease) • Injection, ravulizumab-cwvz (paroxysmal nocturnal hemoglobinuria – type of anemia) • Axicabtagene ciloleucel CAR+ (B-cell lymphoma) • Injection, factor IX, FC fusion protein (recombinant) (hemophilia B) • Rehabilitation acute care • Behavioral health treatment services • Transgender surgery – noncontracted • Injection, teprotumumab-trbw (thyroid eye disease) • Liver transplant • Injection, panitumumab (colorectal cancer) • CAR T-cell therapy, pre-infusion care (adult myeloma) • Hyperbaric oxygen therapy • Orthopedic services (noncontracted) • Gastrointestinal endoscopy • Injection, nusinersen (spinal muscular atrophy) • Referral acupuncture 	<ul style="list-style-type: none"> • Immunological agents – rheumatoid arthritis, psoriasis, inflammatory bowel diseases, atopic dermatitis • Incretin mimetic agents • Antineoplastic Agents (cancer drugs) • Sodium-glucose co-transporter 2 (SGLT2) inhibitors (type II diabetes) • Genetic or enzyme disorder agents • Anti-TNF-alpha – monoclonal antibodies • Hormonal agents (Adrenal) • Antipsoriatics • Ophthalmic agents • Blood glucose regulators • dipeptidyl peptidase-4 (DPP-4) inhibitors (type II diabetes) • Antiobesity drugs • Soluble tumor necrosis factor receptor agents • Gastrointestinal agents • Immunomodulators • Antimigraine Agents • Multiple sclerosis agents • Central nervous system agents • Hepatitis agents • Antiviral drugs • Antirheumatic – enzyme inhibitors • Endocrine and metabolic disorders • Antihemophilic products • Cardiovascular agents • Respiratory tract/pulmonary agents • Eczema agents • Blood products/modifiers – hematopoietic agents • Antidiabetic combinations

Source: California Health Benefits Review Program, 2023.

Notes: (1) Order of services and medications are generally based on the order as reported by health plans/insurers.

(2) **Bold** indicates 100% response rate by responding health plans/insurers.

Trends in Prior Authorization Practices

While CHBRP collected a wide array of information from the health plans, there are significant limitations in the comparability of the information provided. Prior authorization requests for medical services were reported to have increased by 7.6% between 2019 and 2022, among the plans providing information to CHBRP (Table 6).

One plan provided information on Pharmacy Prior Authorization Requests in 2019 and 2022, with frequency remaining pretty constant between the two time periods.

CHBRP found higher prior authorization approval for medical benefits versus pharmacy benefits, after submission of the initial request. That trend widened between 2019 and 2022. Similarly, prior authorization approval rates for medical services, after the submission of additional information requested by health plans, ranged between 74% and 99% in 2022, versus 53% and 68% for pharmacy benefits.

The information CHBRP received on denials, appeals, and resulting follow-ups was limited. However, in general, medical services appear to have higher rates of approval in prior authorization reviews than pharmacy benefits.

Table 6. Trends of Prior Authorization Practices of State-Regulated Health Plans/Insurers

	Medical Services		Pharmacy	
	2019	2022	2019	2022
Requests received (for all responding plans/insurers)	412,667	444,365	*	*
Approvals				
After submission of initial request	69%-100%	73%-99%	54%-75%	44%-59%
After submission of additional information requested by health plan/insurer	73%-100%	74%-99%	58%-75%	53%-68%
Modifications				
Average number of modifications per single prior authorization request	<0.01-1	<0.01-1	N/A	N/A
Requests with any modification (% of total)	0.21%-1.64%	0.15%-1.97%	N/A	N/A
Denials				
As % of total requests	Data not available	Data not available	9%-42%	33%-38%
After initial submission of request	0.45%-29%	1%-25%	9%-39%	10%-41%

As final response to a request	0.45%-24%	1%-24%	0.32%-5%	3%-29%
Appeals				
% of total requests	0.57%-6.06%	0.68%-4.94%	—	—
Decisions upheld	0.71%-55%	38%-79%	—	—
Decisions overturned	0.71%-63%	21%-62%	—	—

Source: California Health Benefits Review Program, 2023.

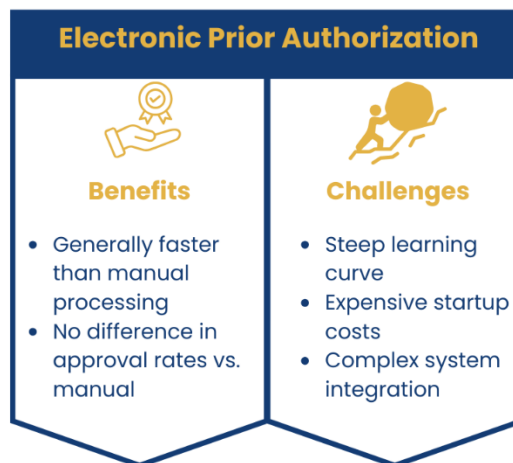
Note: Table results represent the total range of responses from health plans/insurers, not the average percentages across all health plans/insurers.

EFFORTS TO IMPROVE THE PRIOR AUTHORIZATION PROCESS

Over the years, several efforts have emerged to improve the prior authorization process. Some are focused on methods to speed up the process, such as transitioning from manual to electronic authorizations. Others concentrate on minimizing its use, such as the use of “gold carding,” where providers are exempt from the prior authorization process if they meet certain conditions.

Electronic Prior Authorization

Electronic prior authorization has become a focus for several health care stakeholders as a strategy for decreasing waiting times for patients and reducing administrative burden on prescribers. The intent behind the use is to assist health care professionals in submitting requests in a timelier manner and to quickly receive the most recent information on formularies or other covered services (Bhattacharjee et al., 2019; Birdsall et al., 2020). Electronic prior authorization was identified as one of five areas of opportunities for improvement of the prior authorization process by six nationwide organizations of health care providers and health plans (AHIP et al, 2018). Full automation and standardization of the data submission process for prior authorization was also recommended by the Health Affairs Council on Health Care Spending and Value as a strategy to help addressing spending drivers and growth within the U.S. health care system (Health Affairs, 2023).



In an effort to understand the impact of electronic prior authorization on the potential to improve the prior authorization process, AHIP, along with six-member insurance providers launched an initiative called the Fast Prior Authorization Technology Highway (Fast PATH). Two technology companies with electronic prior authorization were integrated into the systems of participating health plans.²³ Over 40,000 prior authorization transactions conducted over 6 months were analyzed by a third-party, independent entity to determine volume, approval rates, and processing time for requests, and compare the measures both before and after implementation of electronic prior authorization. The study found that the median time between submission of a prior authorization request and receipt of the decision was three times faster following implementation of the electronic format, falling from 18.7 to 5.7 hours (Bravo-Taylor and Clayton, 2021; Clayton et al., 2022).²⁴ Approval rates were not impacted by whether the prior authorization request was submitted manually or electronically.

It should be noted that implementation and use of electronic prior authorization is not without challenges. One of the primary issues is the need for the electronic health records (EHRs) to be enabled for electronic

²³ Six health insurance providers that collectively cover over 50 million Americans participated in the project, with Availity and Surescripts serving as the technology partners and Point of Care Partners serving as an expert advisor. RTI International conducted an independent analysis of the project, looking at prior authorization transaction data both before and after implementation of ePA processes and surveying providers on their experiences using ePA technology.

²⁴ With regard to ease of use, 22.8% of all respondents reported it was easier to understand prior authorization information following implementation of the electronic solution, and 34.4% reported that it was easier to understand when prior authorization was required (Clayton et al., 2022); experienced users reported higher rates of understanding if prior authorization was required, and what the requirements were (60% and 57%, respectively) following electronic prior authorization implementation (Bravo-Taylor and Clayton, 2021). Over half of those experienced users surveyed reported a reduction in time spent on phone calls (63%) and faxes (62%) following implementation of the electronic software (Bravo-Taylor and Clayton, 2021).

prior authorization. The cost of purchasing or upgrading EHR software to accommodate electronic prior authorization can be a significant barrier for prescribing providers to its use (AHIP, 2022b). Mid-sized and larger medical groups are associated with higher odds of having EHRs at their practice (Coffman et al., 2015).

In addition, the use of electronic prior authorization does not guarantee that providers will save time. Salzbrenner et al. conducted a nationwide survey of providers related to the use of electronic prior authorization. The authors found that some users of electronic prior authorization for at least some requests submitted a higher volume of prior authorizations and spent more time on submissions than providers who did not use electronic prior authorization software (Salzbrenner et al., 2022).²⁵ The results led the authors to conclude that additional work is necessary to ensure the successful implementation of electronic prior authorization, including efforts to integrate the technology into existing clinical workflows, and designing electronic prior authorization solutions that take a more user-centered approach (Salzbrenner et al., 2022).

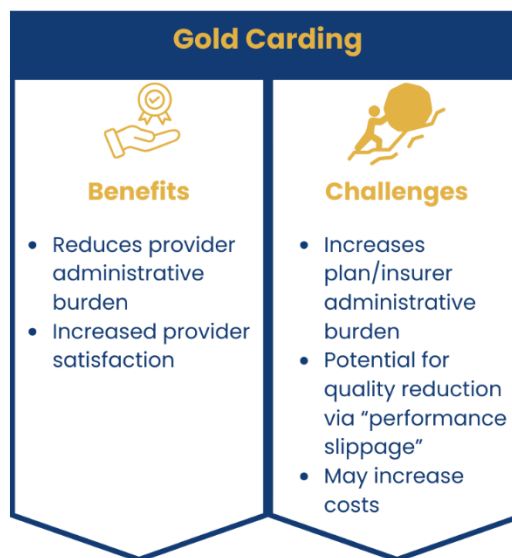
Although electronic prior authorization processes are promising and some evidence shows improvements in speed and effectiveness, integration challenges in the health care system remains, which continue to create challenges.

Gold Carding

One of several recent legislative and policy efforts to reduce the administrative burdens related to prior authorization has been to mandate gold carding programs. Gold carding programs allow for health care practitioners with a high historical record of approval for prior authorization requests of specific health care tests, treatments (including prescription drugs), or services to be exempt from having to make such requests in the future. According to a nationwide survey by AHIP, the percentage of health plans using gold carding for medical services has increased from 32% in 2019 to 58% in 2022; for prescription medications, gold carding has increased from 9% to 21% in the same 3-year period (AHIP, 2022b).

West Virginia was the first state in the nation to allow providers who have had all their requests for a certain treatment approved within a 6-month period to earn a “gold status” card and relieve them of future prior authorization requirements.²⁶ In 2021, Texas passed legislation that would allow providers with 90% of their requests approved to receive a gold card.²⁷ Multiple other states are also introducing gold card legislation.

According to the 2022 nationwide AHIP industry survey on prior authorization and gold carding, health plans using gold carding programs have mixed reviews on their success. About half (46%) of respondents reported a reduction in administrative burden, and the same percentage reported improved provider



²⁵ Sixty percent of users of electronic prior authorization reported that a prior authorization submission request – including gathering clinical documentation – took 1 day or less to complete; another 29% reported that the duration was 1 to 2 weeks. The total duration of time from start to finish for a prior authorization submission did not differ by electronic prior authorization use. However, similar to the results found in study by Clayton et al. (2022), the time to prior authorization decision was significantly shorter for users of electronic prior authorization ($p = 0.004$) (Salzbrenner et al., 2022).

²⁶ West Virginia House Bill (HB) 2351 (2019).

²⁷ Texas HB 3459 (2021).

satisfaction. Although 23% of respondents stated that quality and patient safety remained stable or improved, 33% reported challenges with administrative implementation, 20% reported reduced quality via “performance slippage” by providers, and 20% stated that costs were higher without improved quality (AHIP, 2022b). The latter results highlight some of the challenges related to gold carding, including ensuring maintenance of these programs with changing clinical practices, and additional costs for oversight to ensure consistent care and proper use of the gold card privilege by prescribers (Lenert et al, 2023).

CHBRP's survey found virtually no adoption of gold carding for pharmacy benefits in California. A very limited number of exceptions have been made on a case-by-case basis by one responding health plan/insurer. Another responder previously gold carded a handful of providers for certain surgical services but revoked the privilege after discovery that the providers were conducting procedures inconsistent with their guidelines.

Federal Regulations

In December 2022, the Centers for Medicare & Medicaid Services (CMS) proposed a rule intended to increase the efficiency and transparency of the prior authorization process for certain federal programs. The “Advancing Interoperability and Improving Prior Authorization Processes Proposed Rule” (CMS-0057-P) would impact Medicare Advantage Organizations, state Medicaid and Children’s Health Insurance Program (CHIP) Fee-for-Service programs, Medicaid Managed Care plans, CHIP managed care entities, and qualified health plans on the federally facilitated exchanges (CMS, 2022).²⁸ As of the date this analysis was published, the proposed rules would take effect on January 1, 2026, with the initial set of metrics proposed to be reported by March 31, 2026. The proposed rule affects the following:

- **Application program interface (API):** Impacted payers would be required to build and maintain a specific API to share patient data with in-network providers with whom the patient has a treatment relationship, and automate certain prior authorization processes (e.g., the process to determine whether prior authorization is required, identification of documentation requirements, etc.).
- **Data exchange:** The rule would require impacted payers to exchange patient data, with the patient’s permission, when a patient changes health plans. In addition, if an enrollee has concurrent coverage with two or more payers, those impacted payers must make the enrollee’s data available to the concurrent payer at least quarterly.
- **Denials:** Upon a denial of a prior authorization request, impacted payers would be required to include a specific reason for the denial.
- **Time frames:** The rule would require all impacted payers, with the exception of qualified health plans issuers on the federally facilitated exchanges, to send prior authorization decisions within 72 hours for urgent requests and 7 calendar days for nonurgent requests.
- **Metrics:** Certain metrics regarding prior authorization would be required to be publicly posted on the payer’s website or via a publicly accessible hyperlink on an annual basis.

On June 21, 2023, a letter signed by over 230 U.S. representatives and 61 U.S. senators was delivered to Health and Human Services Secretary Xavier Becerra and CMS Administrator Chiquita Brooks-LaSure requesting that CMS expand on the proposed rule to include the following:

- Establishing a mechanism for real-time electronic prior authorization decisions for routinely approved items and services;
- Requiring that health plans/insurers respond to prior authorization requests within 24 hours for urgently needed care; and
- Requiring detailed transparency metrics.

²⁸ Federally facilitated exchanges operate in states that have not elected to establish their own state-based exchange to allow qualified individuals to shop for health insurance compliant with the Affordable Care Act.

CONCLUSION

Data regarding the use of prior authorization's impacts on care and prevalence remain limited. The peer-reviewed literature base evaluating the impact of prior authorization is relatively limited, and much of the published literature that does exist regarding the impacts of prior authorization focuses on prescription medications. Overall, the evidence regarding whether prior authorization improves patient safety, reduces excess spending, and ensures medically appropriate care is provided, is mixed. Although some studies have shown prior authorization can improve patient safety, reduce utilization of the services or medications subject to prior authorization, and lead to lower expenditures, other studies have found no impact on these outcomes or negative impacts on these outcomes. Additionally, some studies have identified harms such as reduced medication adherence, increased use of other services, and higher overall expenditures. There is a clear consensus from patients and providers that there are substantial challenges when health insurers implement prior authorization requirements for covered benefits. Although prior authorization may be successful in helping to control or limit costs, it is unclear from the available evidence whether prior authorization results in improved health care and health outcomes.

Findings from CHBRP's survey are largely consistent with findings from national surveys and other data. Among enrollees with commercial state-regulated health insurance, all enrollees are in plans or policies with prior authorization requirements for some medical services and about half are enrolled in plans or policies with prior authorization requirements for some pharmacy services. Prior authorization requests account for between 5% and 15% of total claims for medical services and between 21% and 25% for pharmacy services. The share of pharmacy benefit claims subject to prior authorization is consistent with Medicare Part D. Additionally, there is substantial variability among plans and policies regarding which services and medications are subject to prior authorization. This variability can make it challenging for providers and patients to understand when prior authorization is required and what documentation will be required. Further compounding these challenges are technological capabilities facilitated by health plans and insurers through electronic prior authorization and the ability of providers to interact with the systems of health plans and insurers due to their own technological capabilities.

There is a clear challenge for health plans and insurers when making prior authorization policies. Prior authorization can be a tool to assist in reducing excess spending and to ensure medically appropriate care. However, there are frustrations from providers and patients alike, along with documented delays in access to care. While there are efforts at the national, state, and health plan/insurer level to improve the prior authorization process and policies, there are additional factors that contribute to challenges faced. Prior authorization is just one utilization management tool used by health plans and policies, and limitations in adoption of key technology and the lack of clinical guidelines to inform some types of care pose additional challenges. The fragmented nature of the U.S. health care system compounds these challenges because prior authorization ultimately targets person- or provider-level behaviors. Without clear data to inform prior authorization policies, health plans and insurers face a balancing act between using prior authorization to discourage or deny unnecessary or excess health care and ensuring patients are able to access medically necessary care in a timely manner.

APPENDIX A RISK BEARING ORGANIZATIONS

Shared Risk: Health Plans/Insurers vs. Risk Bearing Organizations

Under California law, risk bearing organizations (RBOs) are lawfully organized groups of physicians that deliver, furnish, or otherwise arrange for or deliver health care services. The Department of Managed Health Care (DMHC) states an RBO does all the following (DMHC, 2023):

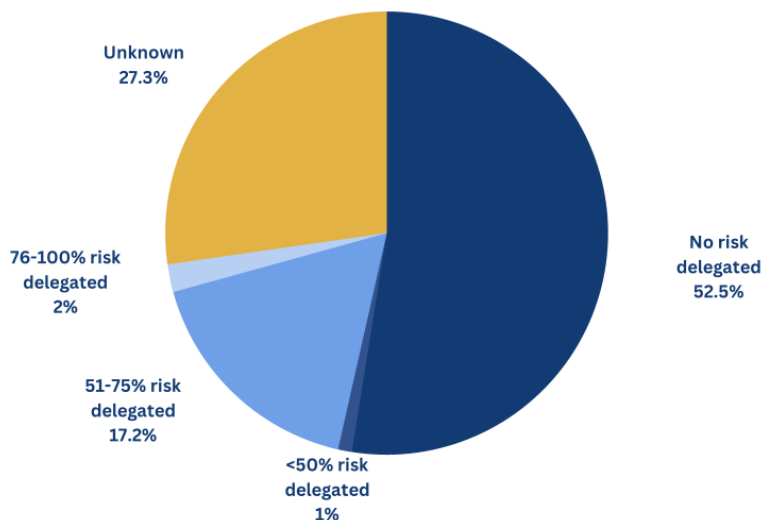
- Contracts directly with a health care service plan or arranges for health care services for the health care service plan's enrollees;
- Receives compensation for those services on any capitated or fixed periodic payment basis; and
- Is responsible for the processing and payment of claims made by providers for services rendered by those providers on behalf of a health care service plan when those services are covered under the capitation or fixed periodic payment made by the plan to the risk-bearing organization.

Examples include medical partnerships, professional medical corporations, independent physician associations, and other corporations controlled by physicians and surgeons; they do not include individuals or health care service plans (DMHC, 2023). Due to the nature of their agreements with health care service plans to provide services at a capitated rate, RBOs often implement value-based care models to their practices. The use of prior authorization within these models is common to ensure appropriate care is delivered to the patient and to help manage costs.

Utilization management functions in connection with HMO products delegate utilization management to a risk bearing organization including a medical group or independent physician association. Generally, PPO products do not shift utilization risk to medical groups, rather these payment models are designed to reward medical groups based on both quality and cost performance, using various quality of care measurements, which include the appropriate utilization of services.

In CHBRP's survey of state-regulated health plans/insurers, responding plans reported just over half of commercial enrollees have health insurance in which no risk is delegated. Nearly 20% of commercial enrollees have health insurance that delegates between 51% and 100% of their risk to an RBO (**Error! Reference source not found.**). Risk may be either financial or for medical management. It is important to note that though risk may be delegated to RBOs, health benefit mandates and related legislation do not always apply directly to RBOs. Furthermore, there is variation among health plans as for which tests, treatments, and services risk is delegated. When risk is not delegated, the financial and medical management responsibilities fall back on the health plan.

Figure 3. Amount of Risk Shared Between RBOs and Health Plans/Insurers



Source: California Health Benefits Review Program, 2023.

Notes: Data include enrollees in state-regulated commercial health insurance, excluding enrollees in CalPERS and DMHC-regulated Medi-Cal Managed Care plans.

APPENDIX B FEDERAL LAWS RELATED TO PRIOR AUTHORIZATION

There are several federal laws that have taken action regarding the use of prior authorization. Additionally, the Centers for Medicare & Medicaid (CMS) has proposed regulations regarding the use of prior authorization for Medicare Advantage plans and Medicaid. More information about these proposals is included in the *Efforts to Improve the Prior Authorization Process* section.

Federal Mental Health Parity and Addiction Equity Act

The federal Mental Health Parity and Addiction Equity Act (MHPAEA) addresses parity for mental health benefits.²⁹ The MHPAEA requires that when mental health or substance use disorder services are covered, cost-sharing terms and treatment limits be no more restrictive than the predominant terms or limits applied to medical/surgical benefits. The MHPAEA directly applies to large-group health insurance, but the Affordable Care Act (ACA) requires small-group and individual market plans and policies purchased through a state health insurance marketplace to comply with the MHPAEA. This federal requirement is similar to the California mental health parity law described previously,³⁰ although the state law applies to some plans and policies not captured in the MHPAEA.

The MHPAEA requires commercial and employer-sponsored health plans and insurers, and certain Medicaid plans, to document the use of, and rationale for, prior authorization for medical and behavioral health care covered services.³¹ Enforcement at both the federal and state levels has recently required health plans to eliminate prior authorization for certain behavioral health treatment due to alleged parity violations.

Affordable Care Act

The ACA prohibits the use of prior authorization on emergency care.³² It also includes reporting requirements for nongrandfathered employer-sponsored plans to report data on claims payment practices and denials, such as reasons for denials. It also requires all group health plans and insurers offering group or individual health insurance coverage to implement an effective process for appeals of coverage determinations and claims, including an internal claims appeal process, and notices in a culturally and linguistically appropriate manner of available internal and external appeals process.

No Surprises Act

The federal No Surprises Act protects enrollees in group and individual health plans from receiving surprise medical bills for most emergency services, nonemergency services from out-of-network providers at in-network facilities, and services from out-of-network air ambulance service providers. With regard to prior authorization, the federal law prohibits surprise bills for most emergency services, even if the enrollee received the services out-of-network and without prior authorization.³³

²⁹ Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), as amended by the ACA.

³⁰ HSC Section 1374.72; INS Section 10144.5 and 10123.15.

³¹ 26 CFR 54; 29 CFR 2590; 45 CFR 146; 45 CFR 147.

³² Section 2719A of the Affordable Care Act; Public Law 116-260.

³³ Public Law 116-260.

APPENDIX C OTHER RELEVANT INFORMATION

Patient Safety Study Details

Starner et al. (2012) examined the utilization of contraindicated medications in conjunction with use of rosiglitazone after the Food and Drug Administration added a warning to the product label in 2007 among commercially insured members who were exposed to prior authorization for rosiglitazone or who were not. There was a significant decrease in unsafe use of rosiglitazone among the prior authorization group. This translates to the potential avoidance of two cardiovascular events among the 59 members who would have used the contraindicated medications in the absence of the prior authorization requirement. However, it is possible that harms occurred due to the prior authorization requirement, which required that a member not use the contraindicated medications to receive approval, because 17 members in the prior authorization group had no antidiabetic therapy claims at 30 days after prior authorization denial. These results are similar to Ross et al. (2012).

Another study that examined the impact of prior authorization on the utilization of dalfampridien, a drug for individuals with multiple sclerosis (MS), found that prior authorization potentially improved safety (Gleason et al., 2013). Among the patients whose prior authorization requests were denied, the reasons included safety concerns and patients not meeting certain criteria of effectiveness for the medication for continued use. However, approximately half of the patients for whom the claim was denied did not seek prior authorization, meaning the claim was denied outright and without evaluation of the appropriateness of the medication for the patient.

Post-Acute Care

As a high-cost area within the health care system, the U.S. Department of Health and Human Services' Agency for Healthcare Research and Quality (AHRQ) states that post-acute care may be an area of interest for cutting costs through measures such as prior authorization (AHRQ, 2021; Cao et al., 2020). Post Acute Care (PAC) focuses on improving activities of daily living (ADL) through physical and occupational therapy and health education (Dolansky et al., 2010). Prior authorization is also used in post-acute hospital rehabilitation, which includes temporary rehabilitation or palliative services following a significant hospital procedure, such as surgery. Some literature points to PAC as involving multiple providers administering aid in a disconnected manner with poor communication (Abrams et al., 2017). In 2021, AHRQ published a topic brief on the impact of prior authorization on patient health care and its general impact on clinicians, providers, and health care systems, in the area of post-acute rehabilitation. However, no studies were found on the subject matter (AHRQ, 2021).

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ABOUT CHBRP

The California Health Benefits Review Program (CHBRP) was established in 2002. As per its authorizing statute, CHBRP provides the California Legislature with independent analysis of the medical, financial, and public health impacts of proposed health insurance benefit-related legislation. The state funds CHBRP through an annual assessment on health plans and insurers in California.

A group of faculty, researchers, and staff complete the analysis that informs California Health Benefits Review Program (CHBRP) reports. The CHBRP **Faculty Task Force** comprises rotating senior faculty from University of California (UC) campuses. In addition to these representatives, there are other ongoing researchers and analysts who are **Task Force Contributors** to CHBRP from UC that conduct much of the analysis. The **CHBRP staff** works with Task Force members in preparing parts of the analysis, and manages external communications, including those with the California Legislature. As required by CHBRP's authorizing legislation, UC contracts with a certified actuary, **Milliman**, to assist in assessing the financial impact of each legislative proposal mandating or repealing a health insurance benefit. The **National Advisory Council** provides expert reviews of draft analyses and offers general guidance on the program to CHBRP staff and the Faculty Task Force. Information on CHBRP's analysis methodology, authorizing statute, as well as all CHBRP reports and other publications, are available at www.chbrp.org.

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CHBRP assumes full responsibility for the report and the accuracy of its contents. All CHBRP bill analyses and other publications are available at www.chbrp.org.

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