

Criteria Based on Medical Evidence to Protect Patients & Contain Costs

A significant portion of health care spending is inefficient or of low value,¹ contributing to excess medical spending that can be harmful to patients. While the majority of clinicians follow appropriate and evidence-based standards of care, when providers deviate from best practices it can result in treatment that is ineffective, unnecessary and, in some instances, dangerous for patients. Prior authorization (PA) and other medical management tools provide a vital check that the care patients receive is safe, coordinated and consistent with evidence-based, clinical guidelines to keep health care as affordable as possible. Both Medicare and Medicaid utilize PA to ensure patients receive care based on well established standards of efficacy and safety.

When developing PA protocols, health plans follow the clinical standards established by leading medical organizations and supported by peer-reviewed research, reviewing their criteria at least annually and updating them more often as new treatments, applications and technologies are deemed generally-accepted professional medical practice. In addition to using standards set by national accreditation organizations, state and federal law require that health plans develop medical necessity guidelines with input from Board-certified, actively-practicing physicians and allied health professionals from the medical specialties within a plan's service area. New York also sets strict turnaround times for reviews, requiring health plans to respond within 3 business days and 72 hours for expedited requests.

An estimated 25% of health care spending is considered unnecessary due to overtreatment, use of low-value care, lack of care coordination, outdated technology and fraud.¹

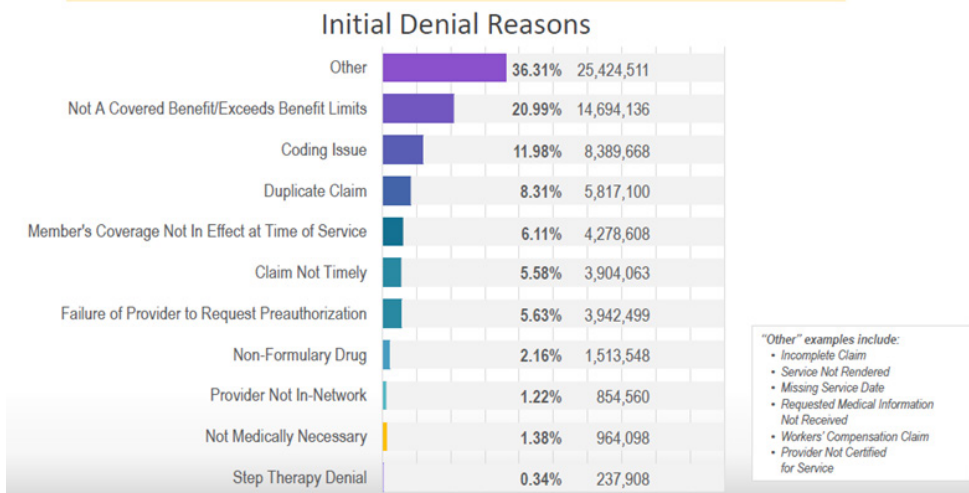
The Vast Majority of Denials are Due to Provider Errors

In 2024, health plans received more than 294 million claims for services – including inpatient and outpatient hospital care, pharmacy, and physician services; approving nearly 73% of claims. Of the 70 million claims that were initially denied, the vast majority were due to provider errors, while slightly more than one percent (1.38%) were determined not to be medically necessary².

Common reasons for denials include:

- Submitting claims for services that were not a covered benefit (20.99%);
- Coding issues (11.98%); and
- Duplicate claims (8.31%).

294MM Claims Submitted in 2024

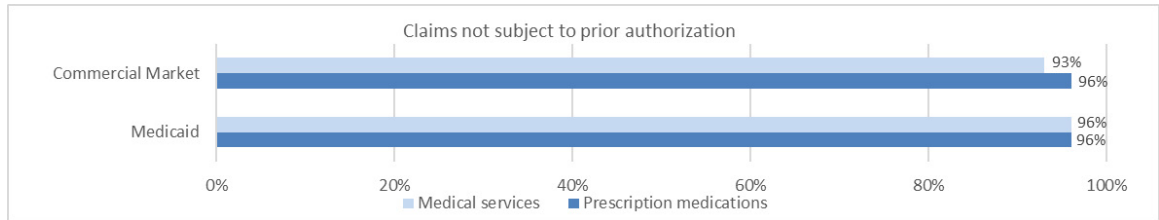


¹ <https://jamanetwork.com/journals/jama/article-abstract/2752664#>

² NYS Dept. of Financial Services Health Care Claims Reports - the most recent full year of data in New York

Small Number of Claims are Subject to PA

According to national data, most care is not subject to PA and the vast majority of requests are approved. More than 90% of commercial claims for medical services and over 95% of pharmacy claims are not subject to PA. For Medicaid, 96% of medical and pharmacy claims do not require prior authorization. For cases that are subject to PA, 97% of medical service and 90% of pharmacy claims in the commercial market are approved, and 97% of medical services and 91% of pharmacy for Medicaid are approved.³



Containing Costs for Consumers & Employers

New York's health care costs are among the highest in the country and per capita spending on health care is 37% higher than the national average. Unnecessary and low value care isn't just detrimental to patients, it also drives excess medical spending and adds to these costs. The Commonwealth Fund's *2025 Scorecard on State Health System Performance* ranked New York in the bottom half of states for Prevention & Treatment (26) and Avoidable Hospital Use & Cost (31). High spending on health care has not led to better quality.

With affordability the top issue in health care,⁴ prior authorization can ensure patients have the option to obtain care from lower-cost alternatives consistent with evidence-based guidelines. For example, PA can help promote the prescribing of generic equivalents where available to protect patients from the high cost of brand name drugs. Further, the use of PA enables health plans to avoid paying duplicate claims and detect fraudulent billing practices that can lead to higher costs for New Yorkers.

Streamlining PA Through Access to Electronic Medical Records

Providers frequently cite PA as an administrative burden. Health plans are committed to simplifying the process, including the use of electronic prior authorization to accelerate patient access to treatment and reduce complexity for providers. Unfortunately, hospitals and doctors continue to rely on manual processes. A 2024 survey found nearly half of PA requests for medical services (45%) and prescription drugs (47%) are currently submitted by providers using phone, fax or traditional mail.

These antiquated and inefficient processes lead to miscommunication and avoidable disputes between health plans and providers – all while the patient sits in the middle. Rather than imposing new restrictions on PA that will undermine quality and care coordination and increase costs, requiring providers to share health information via electronic medical records is a common-sense solution to simplify data exchange, generate cost savings for the health care system, and improve patient care.

³ https://ahiporg-production.s3.amazonaws.com/documents/202506_AHIP_Report_Prior_Authorization.pdf

⁴ <https://news.gallup.com/poll/707732/healthcare-reclaims-top-spot-among-domestic-worries.aspx>