LONG VIEW
THRIVE BY DESIGN

The Lifetime Blindspot

How Different Time Horizons for Payers, Providers and Persons Create Waste

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Shifting Responsibilities for Lifetime Value

Key Learnings

- **Consumers are finding workarounds for a broken prior-auth solution, but "activated consumers" alone won't transform prior-auth**. People are finding ways to overturn denials, even using AI to draft appeal letters, but this energy only kicks in after the damage is done. Without payer-led automation and provider collaboration, member action remains reactive and something more is needed to solve the problem.
- **The payer–provider collaboration is stuck in half measures**. Programs like bundled payments and quality bonuses have limited success because such programs are often payer-dictated rather than co-designed. True collaboration begins when providers seek their largest payer partner(s) and align on outcomes that are impactable by the *providers*, such as A1C control, post-surgical functional recovery, advanced care planning completion, timely post-discharge specialist follow up etc.
- **Never has the need been greater and never has real change in prior authorization felt more within reach**. Costs are rising faster than the economy, new CMS rules force 72-hour turnaround for urgent requests, and coverage churn are all conditions that make prior authorization transformation a real possibility now.
- **A person-centered, payer-led and provider-collaborated solution, one we term the BEACON solution, can truly transform prior-authorization**. The BEACON solution is comprised of bundles that are pre-adjudicated, escalation to peer reviews that occur quickly, advocacy 2.0 for patient/members, a credit and coaching ledger to track provider behavior and outcome navigation through total cost of care (TCOC) predictors.

The Lifetime Blind Spot

In Part 1 of this series, we introduced the concept of the Lifetime Blind Spot, the gap created when payers, providers, and members each operate on different time horizons leading to disjointed incentives for clinical service approvals in a prior-authorization scenario. Payers are measured on annual budgets, providers on episodic revenue, and members living with the long-term consequences of those decisions. This misalignment drives prior authorization behaviors that may save money in the short run but increase costs and harm outcomes over a lifetime. We also shared how payer-provider collaboration has remained underwhelming and does not achieve the ultimate goal of getting the right care to the end person at the right times over their lifetime. Until a lifetime value orientation is adopted, we contend that this lifetime blind spot will continue and prior authorization changes will never reach beyond incremental improvement.

Why Member Activation is Insufficient

Much has been written about empowering members to fight back against prior authorization. In fact, some members are already doing so. Surveys show that one in three adults has appealed a denial, and over half of those appeals are successful (KFF, 2021). Others are finding workarounds. In our own experience, we have observed patients using generative AI tools like ChatGPT to draft denial appeal letters with persuasive clinical language, leading to overturned decisions. Still others have learned to escalate grievances to state insurance regulators, where external review overturn rates can reach as high as 60% depending on the state. These examples show that members are not powerless.

But member action, no matter how clever, is still sporadic. It occurs after a denial has already disrupted care. Even with stronger consumer engagement tools, most patients lack the infrastructure, data, and real-time leverage needed to shift payer decisions at scale. For example, many plans have introduced tools that nudge members to the right site of care and guide them through prior authorization paperwork. While these interventions reduce individual friction, they have not yet shifted systemwide denial patterns. A JAMA Health Forum study found that nearly 94% of MA enrollees still reported barriers to timely care linked to prior authorization in 2022, even as more "engagement" tools were deployed.

The reality is that member activation, while powerful, cannot alone overcome what might be called the structural "run around." Payers still hold the data, the algorithms, and the veto power. Without payer-led automation that streamlines approvals and integrates with provider workflows, member-facing solutions remain reactive rather than preventive. In other words, the system continues to offload work onto the very person it is supposed to serve. The promise of person-centered prior authorization requires not only an activated member, but an infrastructure where their activation is amplified by technology, rather than lost in the noise of administrative barriers.

The Payer-Provider Gap

For years, the industry has called for deeper payer-provider collaboration, but most efforts have limited success. Many programs are one-sided, designed by payers and imposed on providers rather than co-created. The result is a cycle of pilots that rarely sustain. For example, the CMS Bundled Payments for Care Improvement (BPCI) program participation was broad at launch, but by 2020 nearly 50% of hospital participants had dropped out due to misaligned incentives and administrative burden (CMS, 2020). Anthem's experiment with joint bundled care initiatives at Cleveland Clinic also struggled, as providers resisted payer-driven quality metrics that did not reflect local practice realities.

The dynamic often involves health plans monitoring HEDIS measures, and when a score slips, they create an incentive program and deliver it to hospitals and providers after the fact. For instance, if too many diabetic members have an A1C above 9, the plan may set a payment bonus for improvement and push it downstream. Providers, however, are rarely involved in co-designing the program, which limits adoption. For collaboration to work, providers must actively seek their largest payer partners and align around shared clinical goals, rather than waiting for unilateral mandates.

Even when financial carrots are offered, trust remains scarce. A RAND study found that only 27% of providers believe payer incentive programs truly improve quality (RAND, 2021). Collaboration in its current form too often defaults to compliance, not partnership. Until payers and providers can share accountability with the member at the center, the gap will remain.

Why Now?

The healthcare system is standing at a breaking point where delay is no longer an option. Both payers and providers are facing tight financial constraints with high utilization of services. Costs are escalating faster than the economy can sustain, new regulations are collapsing the timelines for decision-making, and the very people the system is meant to serve continue to worsen in health status year after year. What might have felt aspirational a decade ago is now a survival question for payers, providers, and

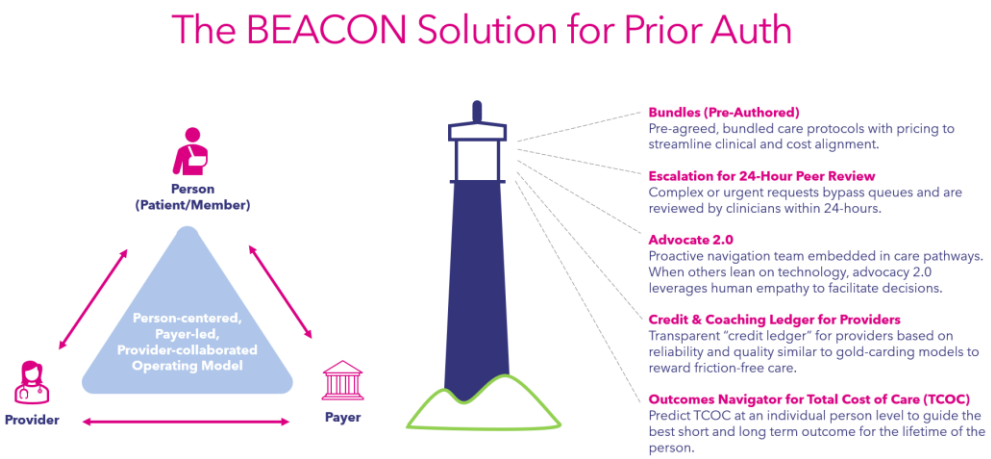
the public alike. Below are reasons why we believe the timing is correct for a deep system-wide transformation for prior authorizations.

1. **Financial pressure is unprecedented**. In 2023, total U.S. health spending jumped 7.5 percent, its fastest rise in two decades outside of pandemic years, reaching $4.9 trillion or $14,570 per person. At the same time, provider expenses continue to outpace inflation, with hospital costs rising 5.1 percent in 2024 compared to 2.9 percent for general inflation. These margins leave no room for inefficiency.
2. **Service demand remains strong with no sign of abating**. The demand for acute, post-acute, ambulatory and ancillary services are not showing any signs of abating. The post-pandemic delayed demand appears to continue and the overall health status of our population seems to be worsening. The various service volume recent trends are shown in Appendix A.
3. **Technology and policy are converging to enable systemic change**. Under the new CMS Interoperability and Prior Authorization Final Rule, payers must deliver decisions on urgent requests within 72 hours and standard requests within seven calendar days, starting in early 2026. These are not aspirational targets, but enforceable timelines. And these could have unintended consequences such as much higher rate of denials pushing requests into the appeal cycle just to ensure timelines are met.
4. **Enrollment volatility continues to undermine continuity of care**. In Medicaid, the typical enrollee covers less than ten months per year, and one in ten people lose and regain coverage within the same year. That kind of churn disrupts both care and cost forecasting. Meanwhile, Medicare Advantage now covers more than half of Medicare beneficiaries, over 32 million people, and commands 54 percent of federal Medicare spending, concentrated in a handful of insurers. This creates both leverage and urgency to align systems with scale.

Taken together, these dynamics change the calculus. Constant churn, extreme cost and service pressure, a regulatory imperative for speed, and massive enrollment concentration make this the moment where a new system, one built around lifetime value, driven by a payer-provider-member bridge, is not only possible but essential.

The BEACON Solution

To close the lifetime blind spot, we propose a five point Beacon Solution (**B**undles, **E**scalation, **A**dvocacy, **C**redit/Coaching and **O**utcomes **N**avigation) that re centers the system on the person while enabling a payer led and provider collaborated transformation. The solution is depicted in the diagram below.



- **Bundles (Pre Authored):** Agree in advance on care protocols that bundle services into packages. Employers and Centers of Excellence programs have already shown this can cut episode costs by up to 45 percent, reduce unnecessary surgeries, and limit financial unpredictability. These bundles streamline clinical and cost alignment.
- **Escalation for 24 Hour Peer Review:** Build a system where complex or urgent requests bypass queues and are reviewed by clinicians within a day. The national Fast PATH initiative showed that moving from faxed requests to fully electronic prior authorization cut decision time from 18.7 hours to 5.7 hours, a 69% improvement. Implementing such speed and transparency dramatically reduces delays.
- **Advocate 2.0:** Modernize the patient advocate into a proactive navigation team embedded in care pathways. For example, a one year pilot across three hospitals in western Pennsylvania reduced excessive emergency department visits by 43 percent, trimmed 30 day readmissions by 60 percent, and raised preventive screenings by 13 percent. This demonstrates that navigation anchored in trust and proximity can shift care utilization effectively.
- **Credit & Coaching Ledger for Providers:** Partnering with providers to create the right behavior and incentive is key. Establish a transparent "credit ledger" for providers based on reliability and quality. This is similar to gold carding models stating who earns friction-free care. The quality metrics can be existing metrics such as HEDIS measures, CMS Stars, PA Turn Around Time because these are well established metrics that are here to stay. Additionally, quality metrics can also be specifically tailored such as Share of patients who fill a prescribed therapy after PA approval, reflecting provider follow-through on pharmacy, copay, and access hurdles or how often a provider must resubmit a PA for the same patient/service, signaling upstream process problems). Lastly, beyond tracking, build in a coaching model is critical so providers can use a culture of competition to build the best ledger. As providers may transfer from one system to another, have the ledger follow them so there is incentive (similar to a credit score) to be in good partnership with payers. While gold card programs are rare today, the principle is proven and could evolve into a fair and dynamic incentive platform that rewards high performance.
- **Outcomes Navigator for Total Cost of Care (TCOC):** Use proven and tailored predictive algorithms for navigating TCOC for not only a population, but also enrolled cohorts (e.g. members enrolled in a care management cohort) and even analyzing an individual persons treatments. For example, GenHealth.ai has created TCOC prediction tools that surpass existing industry and actuarial benchmarks. In certain pilot cases it has proven to show that while a denial of a service may be medically appropriate for the plan, it increases lifetime spend and reduces overall health for the person. Such prediction tools can allow plans to thoughtfully review existing denials and alter clinical policies to align the plan's goals with that of the member.

The Long View

In the long run, the plans and health systems that embrace the BEACON solution will gain long term competitive advantage. They will not only reduce avoidable costs but also gain durable trust from the people they serve. The future winners will be those who coordinate across payer, provider, and person, delivering real-time advocacy, measurable credit for providers, and pre-designed care pathways that take friction out of the system. The key lies in engaging and continually serving the end person as the true center of value. Those who adopt this model will be the ones to survive and thrive in the next era of healthcare.

Appendix A

- **Hospital utilization is rising**. The American Hospital Association projects a 3% increase in inpatient discharges over the next decade, reaching 31 million annually, while total inpatient days are expected to climb 9% to 170 million.
- **Post-acute care is surging**. In 2023, the U.S. post-acute care market was valued at approximately $460 billion, and it is projected to grow to nearly $483 billion in 2024, with a compound annual growth rate (CAGR) of 5% through 2034. Global projections indicate growth from $758.8 billion in 2023 to around $1.41 trillion by 2032, a CAGR of 7.4%.
- **Ambulatory and home-based care skyrockets**. Sg2 projects average growth of 13% over 10 years for home health services and 31% for overall post-acute care volumes, making it one of the fastest-growing segments outside the acute hospital setting.
- **Emergency department volumes are rising**. Sg2 forecasts a 5% growth in emergency department visits over the next decade.
- **Referrals to skilled nursing facilities have doubled**. The 2023 WellSky report notes that since early 2023, referrals from acute providers to SNFs have doubled relative to 2022, and the volume of referrals to home health agencies remains above pre-pandemic levels.
- **Procedural and ambulatory demand is supportive of stronger profit outlooks**. HCA Healthcare has forecasted strong profits into 2025 driven by aged Medicare populations seeking non-urgent procedures and use of ambulatory surgery centers; same-facility admissions have increased 3%, and emergency room visits by 2.4%.

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