NORTH CAROLINA MEDICAL SOCIETY

PRIOR AUTHORIZATION FACT SHEET

WHAT IS PRIOR AUTHORIZATION?

Prior authorization is a process that requires physicians and other health care professionals to obtain advance approval from a health plan before a specific service is delivered to the patient to qualify for payment coverage.[1] This process sometimes includes **Step Therapy**, which requires patients to use—and then fail to be effectively treated by—their insurer's preferred drug treatment before the insurer will cover another drug, even if that other drug is preferred.[2]

WHY IS CHANGING PRIOR AUTHORIZATION IMPORTANT?

93% OF PHYSICIANS Report care delays as a result of prior authorization.[3]

91% OF PHYSICIANS Report that prior authorization can lead to negative clinical outcomes.[3]

Physicians and staff spend more than **13 hours/week** (nearly two business days) on prior authorizations.[3]

Waiting on prior authorization can also lead to treatment abandonment, care delays, serious adverse events, hospitalization, and in some cases lead to permanent impairment or damage in a patient. Some physicians even report hiring a full time staff member to handle prior authorizations.[3]

RECOMMENDED ACTIONS

- Standardization of timelines for approval/denial, so patients do not face delays in care.
- Prior authorization exemptions for clinicians with high approval ratings.
- Public, accessible, and standardized lists communicating treatment and medications that require prior authorization

1. https://www.ama-assn.org/practice-management/prior-authorization/what-prior-authorization
2. https://old-prod.asco.org/node/141656
3. https://www.ama-assn.org/system/files/prior-auth-reforms-issue-brief.pdf

NCMS North Carolina Medical Society

Prior Authorization

Patients with chronic disorders need the same medicine for long periods of time, often a lifetime. Requiring their medication to be pre-approved multiple times a year, through a lengthy and arcane process, creates unnecessary burdens for doctors and causes unnecessary delays for patients.

Background

Prior authorization is a cost-containment process implemented by health insurers to determine whether they will approve coverage for a treatment plan or prescription drug. If the insurer denies approval, but the patient wishes to follow their doctor's treatment protocol, the patient will have to pay for the treatment or procedure out-of-pocket.

Insurers originally argued that prior authorization requirements were needed to discourage doctors from prescribing new, pricy brand-name medications in place of cheaper, equally effective alternatives. But in recent years, health plans have expanded the scope and frequency of their prior authorization requirements far beyond those boundaries. Insurers now commonly require repeat prior authorization for most expensive medicines, and even for generic medications for which no cheaper effective alternatives exist.

- Prior authorization can delay patient access to therapy – and those delays may disproportionately affect patients from underserved communities.
- Prior authorization requests are ultimately approved more than 80% of the time – raising concerns that the real, unstated purpose of prior authorization requirements is to discourage prescribing, regardless of the cost to patient health.

Source: Hemophilia Federation of America

Impact

Prior authorization requirements can delay patient access to medication, leading to excess bleeds and serious health complications for people with bleeding disorders. Overall health system spending increases, too, due to additional clinic visits, extra medication usage, and avoidable hospital stays.

People with bleeding disorders cannot afford such disruptions to therapy. To maintain continuity of care, people with bleeding disorders should not be required to obtain frequently recurring prior authorizations for the products that they routinely take to prevent or control bleeding.

What is Being Done

A growing number of states have adopted prior authorization guardrails. As of September 2020, eleven states have required health plans to respond to prior authorization requests within 48 hours from submission of the request. Seventeen states have adopted standard prior authorization forms. Sixteen states require the use of standard electronic prior authorization processes.

Bipartisan federal legislation introduced in the 116th Congress would have required Medicare Advantage plans to streamline and standardize prior authorization processes. In December 2020, the U.S. Centers for Medicare and Medicaid Services adopted a federal rule that is supposed to make prior authorization decisions faster and more transparent. The rule, which applies to most ACA health plans, took effect on January 1, 2023.