AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

PRIOR AUTHORIZATION AND STEP THERAPY

AAFP Position

The American Academy of Family Physicians (AAFP) calls on prior authorizations to be standardized and universally electronic to promote efficiency and reduce physician administrative complexity. The manual, time-consuming processes currently used in prior authorization programs burden family physicians, divert valuable resources from direct patient care, and can inadvertently lead to negative patient outcomes by delaying the start or continuation of necessary treatment.

Family physicians using appropriate clinical knowledge, training, and experience should be able to prescribe medications and order medical equipment without being subjected to prior authorizations. In the rare circumstances when a prior authorization is clinically relevant, the AAFP believes the prior authorization must be evidence-based, transparent, and administratively efficient to ensure timely access to promote ideal patient outcomes. Additionally, family physicians that contract with health plans to participate in a financial risk-sharing agreement should be exempt from prior authorizations.

The AAFP joined with the AMA and other stakeholders to develop the Prior Authorization and Utilization Management Reform Principles to reduce the negative impact these programs have on patients, physicians, and the health care system. These principles focus on clinical validity, continuity of care, transparency and fairness, administrative efficiency, and alternatives and exceptions.

The AAFP further believes step therapy protocols, in which insurers encourage less expensive prescription drugs to be prescribed prior to more costly alternatives, delay access to treatment and hinder adherence. Therefore, step therapy should not be mandatory for patients already on a working course of treatment and generic medications should not require prior authorization. Ongoing care should continue while prior authorization approvals or step therapy overrides are obtained. Patients should not be required to repeat or retry step therapy protocols that failed under previous benefit plans.

Background

Prior authorization is the process by which physicians must obtain advanced approval from a health plan before the delivery of a procedure, device, supply, or medication for insurance to cover the cost for that service. Health plans use prior authorization as a cost-containment strategy by limiting and restricting access to expensive services. Automation of prior authorization for medications is referred to as electronic prior authorization.

Step therapy is an insurance protocol that requires patients to try one or more insurer-preferred medications prior to a physician recommendation. This practice is also known as “fail first” and can take weeks or months. Once a patient finds a medication that does work for them, they may have to repeat the step therapy process if they switch insurance plans. When implemented inappropriately, step therapy can result in patients not being able to access the treatments they need in a timely manner. Physicians can request exceptions to step therapy requirements, but insurers may not respond promptly to such requests, resulting in a further delay of treatment.

Impact of Prior Authorization on Physicians and Patients

Prior authorization creates an administrative burden for physicians and other health care providers. According to a 2020 survey conducted by the American Medical Association (AMA), 85 percent of

AAFP Headquarters
11400 Tomahawk Creek Pkwy.
Leawood, KS 66211-2680
800.274.2237 • 913.906.6000
fp@aafp.org

AAFP Washington Office
1133 Connecticut Avenue, NW, Ste. 1100
Washington, DC 20036-1011
202.232.9033 • Fax: 202.232.9044
capitol@aafp.org

physicians report that the burden associated with prior authorization is “high” or “extremely high” and 30 percent of physicians report that prior authorization has led to a serious adverse event for a patient in their care. The AMA survey reports that physicians and their staff spend almost two business days each week completing an average of 40 prior authorizations per physician, per week. Studies show providers suffer costs of $11 per manual prior authorization and $4 per electronic prior authorization, which amounted to a total of $528 million in prior authorization costs for providers in 2019.[1] Further, prior authorization interactions with insurers cost practices $82,975 per physician annually.[2]

The AMA survey also highlights the impact of prior authorization on patients: 90 percent of physicians say that prior authorization somewhat or significantly impacts patients’ clinical outcomes. Furthermore, 79 percent of physicians admit that issues related to prior authorization can at least sometimes lead to patients abandoning their recommended course of treatment while 94 percent of physicians report care delays associated with prior authorization. These delays increase wait times for medical services and prescriptions for patients while diminishing access to timely care. Over half of physicians report that prior authorization requirements were never relaxed during the COVID-19 pandemic.

Federal Efforts
The AAFP is a member of the Regulatory Relief Coalition (RRC), a group comprised of physicians' organizations advocating for regulatory burden reduction in the Medicare program, most recently in reforming the use of prior authorization in Medicare Advantage plans. The AAFP has expressed its support for the Improving Seniors’ Timely Access to Care Act (H.R. 3173) which would implement an electronic prior authorization system, improve transparency regarding prior authorization policies, and hold plans accountable for timely responses to prior authorization requests.

State Prior Authorization Activity
Some states have implemented legislation to limit the burden that prior authorization has on physicians and other health care providers. Increasingly, states are requiring insurers to respond to prior authorization requests by a certain deadline. Thirteen states (AL, AR, CA, CO, DE, ID, MA, MS, MO, NH, OR, TN, VA) have a response time of 48 hours, with many adopting a 24-hour limit for urgent care services. Eighteen states (CT, FL, GA, HI, KS, LA, MD, NE, NJ, ND, OK, PA, SC, SD, TX, UT, WI, WY) and DC have no deadline for prior authorization requests.

Legislation has also focused on requiring a standard, universal form for prior authorization, while states are also increasingly moving to electronic prior authorization. Seventeen states (AR, CA, CO, FL, IA, IN, LA, MD, MA, MN, MS, NH, NM, NY, OR, TX, VT) currently have standard prior authorization forms available for physicians, largely for prescription drugs, with Michigan and Washington in the process of establishing a standard form. Fourteen states (DE, GA, IN, IA, KY, ME, MI, MN, NH, NM, NY, OH, VA, WV) with prior authorization legislation require the use of standard transactions for electronic prior authorization that were developed by the National Council for Prescription Drug Programs.[3]

State Step Therapy Activity
States have also moved to limit step therapy protocols. Thirty states (AR, CA, CO, CT, DE, FL, GA, IA, IN, IL, KS, KY, LA, ME, MD, MN, MS, MO, NC, NM, NY, OH, OK, OR, SD, TX, VA, WA, WI, WV) have passed legislation to allow physicians an option to “override” step therapy if the required drug would cause harm to a patient, is expected to be ineffective, or has already been tried under a previous health plan.

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[1] Council for Affordable Quality Health Care. (2020). “2019 CAQH Index: Conducting Electronic Business Transactions: Why Greater Harmonization Across the Industry is Needed.” Web.
[2] Morra D, Nicholson S, Levinson W. Gans D, Hammons T, Casalino L. (2011). “US Physician Practices Versus Canadians: Spending Nearly Four Times As Much Money Interacting With Payers.” *Health Affairs*. Web.
[3] American Medical Association (2021). “2021 Prior Authorization State Law Chart.” Web.