AAFP Backgrounder: Prior Authorization

Prior authorization is among the heaviest administrative burdens on physicians and practice staff. AAFP members report that PA requirements continue to increase, taking time away from patient care and adding financial strain to primary care practices.

Insurers use prior authorizations — which the AMA defines as any process by which physicians must qualify for payment coverage by obtaining advance approval from a health plan before a specific service is delivered to the patient — to limit their costs.

The process adds exceptional administrative complexity but benefits neither clinicians nor patients. In fact, prior authorization delays patient care and is expensive and inefficient. In the rare circumstance that prior authorization or step therapy is clinically relevant, the AAFP believes it must be evidence-based, transparent, and not interrupt timely access to care.

The requirements of PA processes vary based on the specific treatment, test or drug and further differ among health plans and those plans' individual products. These variations burden practices by inflating the volume of phone calls, hold and wait times, and the collection and transmission of medical documents. These considerable burdens are further amplified by cycles of rejection and appeal, which also unacceptably delay patient care and can lead to poor outcomes.

Any health plan requirement that a specific service must be preapproved to qualify for payment coverage burdens practice workflows and drags stymies physician wellbeing. A considerable body of evidence shows that prior authorization confuses and harms patients by delaying their care and reducing or impeding adherence to treatment; research shows that these factors lead to increased morbidity and mortality.