AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

PRIOR AUTHORIZATION AND STEP THERAPY

Recommendation

The American Academy of Family Physicians (AAFP) calls on prior authorization to be standardized and universally electronic to promote efficiency and reduce administrative burdens. 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.

Generic medications should not require prior authorization. The AAFP further believes step therapy protocols used in prior authorization programs, in which insurers encourage less expensive prescription drugs to be prescribed prior to more costly alternatives, delay access to treatment and hinder adherence. Therefore, the AAFP maintains that step therapy should not be mandatory for patients already on a course of treatment. 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 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 in order for insurance to offset 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 has occurred for medications and 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. Seventy-five percent of physicians report that the burden associated with prior authorization is “high” or

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"extremely high." The average physician completes 37 prior authorization requirements each week.[1] Studies estimate that prior authorization costs 1, 13.1, and 6.3 physician, nursing, and clerical hours per week, respectively,[2] and $2,161 to $3,430 annually per full-time equivalent physician.[3] Further, prior authorization interactions with insurers cost practices $82,975 per physician annually.[4]

The burden of prior authorization also has an effect on patients. Ninety percent of physicians report that prior authorization sometimes, often, or always delays patient access to care. Nearly 60 percent of physicians report waiting at least one business day for a prior authorization decision from a health plan while 26 percent report waiting at least three business days.[5] These delays increase wait times for medical services and prescription medications for patients while diminishing access to timely care.

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. Ten states (AL, CA, DE, ID, MA, MS, NH, OR, TN, VA) have a response time of 48 hours, with many adopting a 24 hour limit for urgent care services. Nineteen states (CT, GA, HI, IN, KS, KY, LA, ME, NE, NJ, ND, OK, PA, SC, SD, UT, WV, WI, WY) 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, LA, MD, MA, MN, MS, NH, NM, NY, OK, OR, TX, VT) currently have standard prior authorization forms available for physicians, largely for prescription drugs, with Michigan and Vermont currently in the process of establishing a standard form. Sixteen states (CA, DE, GA, IN, IA, KY, MD, MN, NH, NM, NY, OH, TX, VT, VA, and 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.[6]

State Step Therapy Activity

States have also moved to limit step therapy protocols. Fourteen states (CA, CO, CT, IA, IN, IL, KS, KY, MD, MS, MO, NY, TX, WV) now allow physicians an option to "override" a 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. Step therapy override protocols take effect in Minnesota and New Mexico in 2019, while Louisiana's override protocols apply only to its Medicaid program. Oregon requires insurance companies to remain transparent with their step therapy protocols.[7]

Prior Authorization and Utilization Management Reform Principles

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, providers and the health care system. Together this group advocates with health plans, benefit managers and any other party conducting utilization management, as well as accreditation organizations, to apply its principles to utilization management programs for both medical and pharmacy benefits. The coalition produced 21 principles that could improve prior authorization programs by applying the principles' concepts grouped in five broad categories – clinical validity, continuity of care, transparency and fairness, timely access and administrative efficiency, and alternatives and exemptions.

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[1] American Medical Association (2017). "2016 AMA Prior Authorization Physician Survey." Retrieved from https://www.ama-assn.org/sites/default/files/media-browser/public/government/advocacy/2016-pa-survey-results.pdf

[2] Casalino L, Nicholson S, Gans D, Hammons T, Morra D, Karrison T, Levinson W. (2009). "What Does It Cost Physician Practices To Interact With Health Insurance Plans? *Health Affairs.* Web.

[3] Morely C, Badolato D, Hickner J, Epling J. (2013). "The Impact of Prior Authorization Requirements on Primary Care Physicians' Office. *Journal of the American Board of Family Medicine*. Web.

[4] 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.

[5] American Medical Association (2017). "2016 AMA Prior Authorization Physician Survey." Retrieved from https://www.ama-assn.org/sites/default/files/media-browser/public/government/advocacy/2016-pa-survey-results.pdf

[6] American Medical Association (2018). "2018 Prior Authorization State Law Chart." Web.

[7] National Psoriasis Foundation. (2018). "Step Therapy Legislation by State." Web.