



NHC Report: Exploring the Burden of Prior Authorization on Patients with Chronic Disease

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EXECUTIVE SUMMARY

The United States' health care system contains a network of insurance plans and processes that are frequently difficult for patients to navigate. Practitioners are often required to work with health care insurers to determine the medical necessity of a drug or service through a process called prior authorization (PA). While PA is often intended to protect patients, it can be a lengthy process that delays treatment and impacts the quality of care. To alleviate these challenges, improve workflow and PA use, some federal and state level policies have been implemented to address the shift towards electronic health records and amend the overall PA process. To help the patient community follow and understand these policy changes, the National Health Council (NHC) has developed this report detailing current PA policies and recommendations as of November 2023. Watch for future NHC Reports on additional Utilization Management techniques, such as Step Therapy, and other health systems' practices that create barriers to patient access to medicines and care.

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BACKGROUND

In navigating the intricate health care system of the U.S., utilization management tools such as prior authorization have become a burden to patients living with a chronic disease and/or disability. PA is an insurance review process to determine coverage of a medication or service after prescription. Its purpose is to reduce overutilization of potentially addictive medication and inappropriate or inefficient care that can cause negative consequences such as drug-to-drug interactions. PA protocols often involve consensus from a group of medical experts with the intent to determine whether a drug or service is necessary and how much a patient's insurance will cover. However, development of protocols does not typically include the perspective of the patients most impacted and may not include hyperspecialized providers, such as those who are experts in rare diseases. The PA process is commonly used by both private and public insurers, although the process is often critiqued for its burden on patients and providers.

Processing requests for PA can have severe impacts on usage of health care services and ultimately clinical outcomes. Many chronic diseases such as diabetes, epilepsy, and cancer require daily medication and/or frequent health services. However, PAs can be a barrier to access to care, especially for patients with diseases that require specialized treatment. PAs are time intensive, creating delays for necessary drugs, medical devices/products, or services related to the diagnosis and treatment of a disease. For example, a 2021 study among inflammatory bowel disease (IBD) patients showed that delayed approval or denials of corticosteroids for IBD control led to a 14% higher likelihood of disease progression and symptomology from moderate to severe.¹ In addition, there was also an approximately 13% increased likelihood of IBD-related health care visits.¹ For patients with other diseases such as chronic kidney disease (CKD) and type 2 diabetes, PA has become an obstacle in receiving timely treatment leading to adverse outcomes including progression of CKD, cardiovascular complications, and hyperglycemia.² These denials interfere with the continuity of care for chronic conditions, further widening disparities among patients.

For people with chronic conditions, PA requirements and the inconsistent approval process are detrimental to long-term outcomes and disproportionately affect historically underrepresented racial and ethnic (HURE) communities, those experiencing low socioeconomic status, and older adults. The time required per claim and other administrative burdens during the process can bar providers in medically underserved areas from prescribing or providing the best options for their patients.³ A 2022 study involving cancer patients showed that non-Hispanic Blacks, non-Hispanic other/mixed race, and Hispanics/Latinos were three times more likely to experience an insurance denial compared to their non-Hispanic white counterparts after a cancer diagnosis.⁴ Older adults also have higher insurance costs and are more likely to be denied coverage, especially by private insurance, due to pre-existing or chronic conditions.⁵ Further, delays and/or denials can increase out-of-pocket costs that may be difficult for patients to afford, further widening socioeconomic disparities.³ As the PA process continues to progress, policy makers and those involved in the process will need to better address the disparities within these communities.

The PA process negatively influences patient and provider experience with health insurance. According to a 2023 KFF survey of over 3,500 adults who are insured, around 16% reported issues with denied or delayed PA for a treatment, service, visit, or drug.⁶ On the other side of the clinical interaction, a 2022 AMA survey revealed that 94% of physicians reported that PA delayed patient access to necessary care, 89% believed PA interfered with continuity of care and 58% felt that PA negatively impacted their job performance as they spend more time reviewing PA claims rather than effective patient engagement.^{7,8} 33% of physicians also reported serious adverse events to patients as a result of PA, including hospitalizations, life threatening events, and/or permanent bodily damage.⁸ As these issues arise, it is vital that there are health policy improvements, patient and provider education, and improved communication to help patients understand their insurance policies and whether they are a right fit for them.

POLICY LANDSCAPE

The consequences of delayed care caused by PA have garnered mass attention from the patient and medical communities. Adverse impacts of PA on patients such as hospitalizations and bodily damage, as well as rising concerns from providers, have resulted in recent attention from federal and state governments. Federal and state entities have proposed and implemented changes to create more efficient PA processes.

Federal Trends

In December 2022, the Centers for Medicare & Medicaid Services (CMS) released a proposed [rule](#) on advancing interoperability and improving prior authorization processes. In the proposed rule, CMS emphasized the importance of electronic health records in the continuity of care, clarification of PA use in insurance plans, and requiring the adoption of electronic PA standards for clinicians and plans.

Concurrent to the interoperability rule, CMS also issued their 2024 Medicare Advantage and Part D [Final Rule](#) which was finalized in April 2023.⁹ In the rule, CMS revised Medicare Advantage and other Medicare programs' regulations surrounding PA. In the final rule, CMS aims to minimize barriers for Medicare recipients seeking necessary care. Provisions in the final rule include:

- PA policies for coordinated care plans may only be used to confirm the presence of diagnoses and/or ensure a service is deemed medically necessary;
- Medicare Advantage plans must follow national and local coverage determination and general coverage and benefit conditions included in Medicare laws;
- PA approvals must be valid for as long as medically necessary, and plans must provide a minimum 90-day transition period for enrollees switching MA plans, who are undergoing active medical treatment; and
- PA should align with clinical guidelines and peer-reviewed clinical studies when updated guidelines are unavailable.

In June 2023, 294 members of the United States House and Senate signed a bipartisan letter urging CMS to implement changes to “increase transparency and improve the PA process for patients, providers and health plans.”¹⁰

Outlined in the letter, congressional leaders offered support of CMS' December 2022 proposed rule on PA but asked them to go further and emphasized the importance of aligning it with the Improving Seniors' Timely Access to Care Act, which previously passed the House unanimously in September 2022.^{11,12} Shared aspects of the proposed rule and legislation include:

- Acceleration of PA decision timeframes;
- Establishment of an electronic PA process for Medicare Advantage plans;
- Expansion of beneficiary protections to improve patient experiences and outcomes;
- Increased transparency on PA requirements and clinical information needed to support decisions; and
- Reduction of administrative burden for providers and health plans.

State Trends

Across the U.S., state legislatures have taken aim at improving PA. In 2023, over 80 bills have been introduced in state legislatures to reform PA. The heightened attention on PA since the COVID-19 pandemic echoes its significance on impacting patients' lives and the health care system. Following CMS' initiatives to mitigate PA through their 2024 Medicare Advantage and Part D Final Rule, more states have embarked on rectifying the PA process. For example, New Jersey Assembly Bill 1255, Ensuring Transparency in PA Act aims to reduce barriers by reducing the volume of PA requirements for patients with chronic conditions.¹³ Similarly, North Carolina's House of Representative passed North Carolina Bill 649, Ensure Timely/Clinically Sound Utilization Review.¹⁴ The bill aims to give patients more timely access to medical care by reforming the prior authorization process. Both bills remain in committees and have not moved to floor votes.

Despite progress, potential impacts are limited. As state and federal entities try to reform PA, the National Health Council has created policy recommendations to inform providers, patients, and other members of the health care community.

POLICY PRIORITIES

In previous [comments](#) the NHC applauded CMS' goal of reducing barriers for patients to access quality care. While NHC is pleased the CMS final rules took steps to mitigating barriers to services, it did not address prior authorization requirements for prescription drugs. Moreover, the proposed rule lacked requirements around formulary feedback from patient communities, timely responses to PA appeals, and plan accountability surrounding utilization management tools.

The NHC has identified several priorities areas to improve prior authorization, some of which has begun to be addressed through the aforementioned CMS rules, some of which would be addressed through proposed legislation, and some that have yet to be considered by policymakers. These priorities are expressed through our Domains and Values on [Utilization Management](#), which was approved by the NHC Board in July 2023 as outlined below:

Ensure Appropriateness and Transparency of PA Policies

- Plans should ensure PA protocols are aligned with clinical guidelines and/or peer-reviewed clinical studies are imperative in improving PA policies.
- Plans should provide more transparent and health literate information on PA protocols to alleviate barriers surrounding decisions and practices.
- Plans should grant PA appeals or exception requests when certain circumstances are met that are in the best interest of the patient and are clinically appropriate.

Increase the Timeliness of Utilization Management Decisions

- Plans should implement electronic PA standards, and providers should adopt them, to minimize patient burden. The development of electronic PA infrastructure would benefit patients and providers by speeding up administrative processes and give access to care in a timelier fashion.
- Electronic PA infrastructure should be developed to support timelier execution of other forms of utilization management in the future.
- Policymakers should implement specific time-bounded standards to ensure plans respond to PA quickly.

Minimize Patient and Provider Burden

- Policymakers should enforce that patients and providers are not subjected to repeated PA.
- Plans should develop PA protocols that are aligned by the perspectives of people living with chronic diseases and disabilities and clinical experts.

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