Reform Prior Authorization

Talking Points

- Prior authorization (PA) is the requirement that a physician obtain approval from the health insurance plan before a patient can receive a treatment or medication. This requirement not only puts an administrative burden on physicians, and/or their staff, but also on patients and payers.

- On average physician practices complete 45 prior authorizations per week, this amounts to an average of 14 hours a week being spent on PA's. This also doesn't account for denied or incomplete requests wherein the missing information is collected, and the application resubmitted. Which extends the period of time that a patient goes without receiving care.

- PA has been identified as a major source of burnout for providers – particularly in rural or small practices where they cannot afford to have dedicated staff identifying, collecting, and submitting the information required for a prior authorization request.
    - This also hinders the recruitment and retention of physicians to these practices and redirects the resources they do have, away from patient care.
    - Similarly, payers are having to expend considerable resources towards operating their prior authorization programs which may not promote health care quality or reduce health care spending to the intended degree such that it doesn't justify the programs administration.

- Prior Authorization hurts patients because it can lead to care delays, treatment abandonment, and in some cases, serious adverse events.

- Recognize that the process interrupts timely care for patients and inherently detracts from the goal of the program – which is to promote the quality of health care or reduce health care spending.
    - Not allowing the patient to receive care the day they are at the office leaves open the opportunity for their condition to worsen, which may require more costly services. This is of particular concern for patients who travel far distances to receive care and are less likely to return to the clinic when approval does occur.
    - Additionally, this is economically harmful to both the patient and their employer because they are not able to work at their most productive level and will have to take off more time if they do return to the clinic for treatment.

Legislative Ask

- **Support HSB 641 which addresses administrative burden by reforming prior authorization.**
  Introduced by Representative Lundgren, crafted collaboratively by IMS and Wellmark
    - Will change the response time of a prior authorization request to within 48 hours for an urgent request, within 10 calendar days for non-urgent, and 15 calendar days for non-urgent if there are complex circumstances or unusually high volumes of requests.
    - Will require health carriers to implement a pilot program that exempts a subset of participating providers, including primary health care providers, from certain authorization requirements and to complete an annual review of the services requiring prior authorization and whether it is necessary.