

# Prior Authorization Exemption

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## KMA Member Survey Results

**82%** of physicians said that issues related to the prior authorization process sometimes, often, or always lead to patients' delays or changes to patients' recommended course of treatment.

**7 in 10** physicians said that the amount of work associated with the prior authorization process has increased in recent years.

Over **half** of physicians said that the burden associated with prior authorizations is extremely high or high.

**81%** of physicians said the prior authorization process delays access to necessary care for patients sometimes, often, or always.

KMA **supports** legislation which would establish a prior authorization exemption program designed to automatically waive prior authorization requirements if a physician has historically been approved for a specific procedure/service most of the time (e.g. 90 percent). This prior authorization exemption program would ensure patients have timely access to the care they need, reduce administrative burdens for physicians, and lower healthcare costs.

# Projected Annual Cost to Kentucky Providers Who Serve Medicaid Patients

	All KY MCOs (May 2022 – May 2023)
<b>Total PA Request (All KY Medicaid Providers)</b>	<b>882,470</b>
<b>Avg. Cost to Medicaid Providers Per PA</b>	<b>\$8.25</b>
<b>Annual Cost to All Medicaid Providers</b>	<b>\$7,280,377.50</b>

- The largest source of health system waste, roughly \$266 billion, is due to administrative costs that stem from processes like prior authorization. ([PGPF, 2023](#))
- A national survey of 925 physicians and administrators found that physicians spent a median of 4 hours per week on drug utilization management, while nurses spent 15 hours and other staff spent between 3.6 and 10 hours per physician per week. This time was associated with a calculated median dollar value of \$75,927 per physician per year. ([NIH National Library of Medicine, 2022](#))
- A 2022 American Medical Association survey of more than 1,000 practicing physicians from across the country, revealed that physicians complete on average 45 prior authorizations per week per physician, and that 2 in 5 physician offices have staff that work exclusively on prior authorization requests. ([AMA, 2023](#))
- In a 2020 CoverMyMeds Annual Report, they estimate that 7% of all prescription claims nationwide are rejected due to PA and 37% of those prescriptions are abandoned by patients. As 5.8 billion prescriptions were dispensed in 2018, PA could be the cause of over 150 million patients not getting the medications they need. ([CoverMyMeds, 2020](#))

# Prior Authorization Myth vs. Fact



## INSURERS CLAIM

Prior authorization is based on medical evidence and nationally recognized clinical guidelines.

Prior authorization promotes cutting-edge care by reinforcing providers to smooth out knowledge gaps in a world where medical knowledge now doubles every 73 days.

Prior authorization encourages the use of generic medications, lowers the rates of abuse of opioid medications, steers patients and doctors away from low success procedures and treatments and red flags scenarios that are often the hallmarks of scam artists and bad actors. The more fraud and inappropriate care, the higher the per member per month premiums.



## REALITY

First, insurers will frequently utilize the phrase “medical evidence” but do not share the source of such evidence. If citations are provided, they are often not from respected US peer-reviewed journals. Second, the phrase “nationally recognized clinical guidelines” is often used by insurers to describe their own national guidelines. Even when insurers reference legitimate nationally recognized medical specialty society guidelines or peer reviewed medical journal evidence, insurers will likely include a disclaimer that allows them to apply exclusions or inclusions to those national medical specialty guidelines.

“Cutting-edge care” is a reference to an area of medicine deemed experimental or investigational and typically encompass services that are not commonly covered by insurance plans. While prior authorization may be appropriate for those services, insurers often require prior authorization for proven, non-experimental, non-investigational healthcare services that are within long-standing, well-established standards of care – services that patients need and utilize most.

In limited circumstances, prior authorization, when done correctly and effectively, can help monitor and manage care. In current practice, however, insurers’ use of prior authorization is neither correct nor effective in determining what services should and should not be provided. Rather, the process often limits access to care, limits the provision of medical care, and creates burdens and barriers for patients, especially those with chronic conditions. A prior authorization exemption program can ensure proper checks and balances without inhibiting patient care.

# Prior Authorization Myth vs. Fact



## INSURERS CLAIM

The federal government is in the process of finalizing comprehensive rules that, among other matters, will govern prior authorization processes and procedures of health plans. To avoid conflicting requirements, states should defer any legislative or regulatory action on prior authorization while these new federal rules are being finalized.

The fiscal impact statement on HB 134 [prior iteration of prior authorization exemption legislation] amounts to an increase of up to \$12.44 per member per month, or \$591.84 per year for a family of 4. This does not include the state employee plans or Medicaid.



## REALITY

Pending federal rules, which may or may not be finalized and implemented as outlined, primarily impact the timelines and electronic processes surrounding prior authorization and only for those plans that are regulated by federal law.

Besides, Kentucky law already addresses timelines and electronic processes. Nothing in the proposed federal rules address a prior authorization exemption program other than to state, "We [CMS] encourage payers to adopt gold-carding approaches that would allow prior authorization exemptions or more streamlined reviews for certain providers who have demonstrated compliance with requirements. Gold-carding policies could reduce burden on providers and payers, while improving the patient experience. By taking this step, payers can join CMS in helping to build an infrastructure that would allow clinicians to deliver care in a timely and value-based manner."

The referenced fiscal impact statement was largely based on information provided by America's Health Insurance Plans and the Texas Association of Health Plans, two entities which oppose prior authorization exemption programs.

Conversely, an impartial national study estimated the annual indirect and direct costs for prior authorization and other administrative burdens were between \$23 to \$31 billion.

Additionally, representatives from the Department for Medicaid Services (DMS) recently testified before the Interim Joint Committee on Health Services and said that based on preliminary data, DMS did not see a significant increase in costs due to removal of prior authorization for all services during the pandemic. Prior exemption programs will help save on indirect and direct costs that unduly burden physician practices and the patients they serve.



# Prior Authorizations Are Harming Kentuckians

*Kentucky Physicians share the impact of prior authorizations on their patients and practices:*

## Unexpected Costs

"Many pregnant women in our area struggle with anemia. We are trying to avoid blood transfusions by treating women with IV iron so their anemia improves before delivery. However, the prior auth for IV iron can take weeks and we don't have that kind of time in the third trimester of pregnancy. One woman decided to go ahead and get her IV iron before the prior auth was done. She received a bill for \$1000.00."

-OBGYN, Morehead

## Complicated Administrative Work

"I had a prior authorization for a patient with hearing loss who we had requested a CT scan for. The reason we requested a CT scan instead of an MRI was clearly included in the patient's notes. After being told we'd need to have a "peer to peer" review for the case, we were told we'd need to *hand-write* the reason for the request, even though it was already included in the notes! Just an example of the absurdity of the prior authorization process and the unnecessary hoops we are forced to jump through."

-Otolaryngologist, Paducah

## Multiple Visits and New Medications

"I often have to resend PA for old medications that the patients have been on for many years.... Once they are established on these meds and the insurance decides not to cover it, I have to find other medications to help their blood pressure and have to come back multiple times in the office to make sure the new medication is tolerated and that it works."

-Primary Care, Louisville

## Life-Threatening Delays

"I have run into the issue where a patient will be in route to the hospital due to kidney stones and insurances... take at least 72 hours. I always explain to them the situation, but they always ask the question is it "life threatening?" Which I don't like because then you feel like you have to say yes, or they won't mark it "urgent." I think insurances look at "urgent" as life or limb situations, but sometimes the patient is in *extreme pain* and needs medical attention, so it doesn't *become* a life-threatening scenario."

-Urology Practice Administrator, Louisville

**"We do not have enough hours or staff to deal with the amount of prior authorizations we have to do."**

**"Oncology patient required anti-nausea medication that required prior authorization. In the approximately 3 day interval it took to get authorization, patient was readmitted to the hospital with nausea, vomiting, dehydration, renal failure and electrolyte abnormalities."**

**"Patient died of a hypoglycemic event and drowning while he was waiting on a PA for a continuous glucose sensor"**

**"What price do we put on healthcare and at what cost is a patient's life worth?"**



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