

Prior authorization abuse: It's time for health insurance CEOs and their proxies to cease and desist the practice once and for all!

...or they should be fined, or sent to sit in the corner on 2-foot-tall plastic Little Tikes® chairs for a “time-out” (dunce cap optional)



James A. Simon, MD

Dr. Simon is Clinical Professor, Department of Obstetrics and Gynecology, George Washington University, and Medical Director, IntimMedicine® Specialists, Washington, DC.

Before reading this editorial and concluding that the author (me) has lost his grip on reality, I would ask that you consider the facts I provide below and the ramifications incurred by your patients and practices, due to the misbehaviors adopted by the health insurance industry.

- Two of the most common issues discussed in today's health care environment are revenue generation and provider/staff burnout.

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While these issues are impacted by several factors, one of the most common denominators is increasing administrative workloads driven by non-revenue-generating activities. Consider this:

- A recent American Medical Association survey pointed out that during the course of the average workweek, a physician completes an average of 37 prior authorization requests. Physicians and their staff spend an average of 16.4 hours per week completing prior authorization requirements for patient medicines, procedures, and medical services that they may need.¹
- While physicians report that about 65% of prior authorizations take only 1 day, they report that 26% take 3 or more days.²

The potential significance of the generated delays

While this may not seem like a long time (other than the impact it has on staff workload), consider the impact

this can have on the patient if the medication being requested is: PrEP, the morning after pill, or other contraceptives? The consequences of the delay or denial could be a lifetime living with HIV, or an unintended pregnancy. This is to say nothing on the larger impact to family, partners, and the potential social stigma faced by all.

Beyond the personal costs and costs within your practice associated with the additional workload, consider the financial costs. The average cost to complete a prior authorization remains the single highest cost for the health care industry at \$13.40 per manual transaction, and \$7.19 per partially electronic web portal transaction,³ meaning that if I did only one prescription per week, I probably would not mind, but at \$13.40 per prior authorization, this burden amounts to millions, actually \$767 million by recent estimates.³ Additionally, if you factor in the number of denials and potential follow-ups, this creates a significant amount of waste and spending.

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Ultimately, in my experience, I have found that most prior authorizations are simply unnecessary. Here, I've picked key examples from just my own recent experiences:

1. My patient was denied access to a particular birth control pill she had been on successfully before, and my office was told she needed to try and fail on 5 different generic pills before she could be approved. However, the Affordable Care Act's (ACA; aka Obamacare) Contraceptive Mandate requires coverage of all contraceptives determined to be most appropriate between a patient and their provider (see below).
2. A menopausal patient was denied coverage twice (electronically) for generic micronized progesterone, and I was asked to write a letter of appeal because the insurance company wanted me to use medroxyprogesterone acetate instead. Polling my nearby retail independent pharmacy, the total cost difference per year was \$19.96 savings/year (\$47.01 - \$27.05 = \$19.96). My pharmacist did note it could have been a different amount at a large chain pharmacy. Really? I had to write a letter, following two denials, to save less than \$20, for a full year!
3. A 78-year-old patient using Prolia for severe osteoporosis and preexisting fractures was delayed in getting her next Prolia injection due to a prior authorization snafu. She ended up with multiple additional fractures, a well-described effect of the increase in bone turnover when stopping or delaying this medication. She is now disabled.
4. A 94-year-old patient was sent an email reminder to get the medical practice to authorize a refill of ileostomy bags. The email went to spam, and the patient ran out of bags prior to a holiday weekend.

I got them in 2 days on Amazon Prime. But who emails a 94-year-old? And ileostomy bags! When does anyone stop needing ileostomy bags?

5. I requested a prior authorization for Orilissa (clearly off label) because a severely progesterone-sensitive patient (augmented depression) with severe premenstrual dysphoric disorder requiring hospitalization was thought by her psychiatrist to be better off without menstrual periods. I completed the proper paperwork, two electronic appeals, and a letter of explanation including available references on the use of gonadotropin-releasing hormone analogues for such patients. I was then told I would need to have a peer-to-peer discussion, so I filled out that paperwork, which clearly noted that I am a board-certified reproductive endocrinologist. I got a phone call a few days later by a pleasant, young-sounding pediatric rheumatologist. Our interaction did not go well for him. This was not peer-to-peer!

Let us be clear, prior authorizations have **nothing to do with patient care**. In fact, they are solely about the money. We in ObGyn have mostly inexpensive and generic products, but even that fact has not lowered the excessive burden of the prior authorization process. In the case of contraception, whether you like the ACA or not it is the law, and it contains specific provisions regarding contraception. With the goals of providing broad access to patients and incentives to developers for new and novel contraceptive methods, these provisions require insurers to cover, without cost-sharing, women's preventive services including the full range of FDA-approved contraceptives (currently 18 different method categories), and additional methods

identified by the FDA as they become available. Further, providers must have an easily accessible, transparent, and sufficiently expedient exceptions process that is not unduly burdensome on the individual or a provider (or other individuals acting as a patient's authorized representative).

And while I can regale you with chapter and verse and citations of the legal precedent and language, it boils down to this:

- The AMA reported that medical practices spend an average of 2 business days a week per physician to comply with health plans' inefficient and overused prior-authorization protocols.⁴ To keep up with the administrative burden, 2 out of 5 physicians (40%) employ staff members who work exclusively on tasks associated with prior authorization.⁴
- About 86% of practices reported an increased burden of prior authorizations in the last 5 years.⁵

What is to be done?

I do have suggested solutions. Given the insurance industry's complete lack of progress in voluntarily reducing the burdens of prior authorizations agreed to in their consensus statement with the AMA, American Hospital Association, America's Health Insurance Plans, American Pharmacists Association, Blue Cross Blue Shield Association, and the Medical Group Management Association, I say, why not fine them? The AMA is calling on Congress to pass legislation that would codify much of the agreement, in which the above parties had already agreed that reforms were needed to reduce prior authorization burdens and enhance patient-centered care.⁶

A good model for enforcement via fines could be based on the old "incident to" rules of Medicare. These

state that a physician needs to be “in the space” when advanced practice nurses or physician assistants see Medicare recipients. If they are not actually “in the space” they are subject to a fine. As a completely theoretical example, let’s say the claim was for \$100. The practitioner would have to pay it back plus triple that amount in damages, or \$400. They can also be fined up to \$11,000 per claim and kick you out of Medicare and Medicaid. Take my example of Prolia from above...a single shot of Prolia is about \$1,000. The insurer would theoretically have to pay \$14,000/claim (the claim + triple damages + \$11,000) if it

was determined that the prior authorization was unnecessary. Seems about right to me. Or we could just sit the health insurance CEOs and their proxies in the corner on 2-foot-tall plastic Little Tikes® chairs for a “time-out” (dunce cap optional), like the outset of the article says.

Until the detrimental prior authorization process is challenged at all levels, we will continue to see and feel the effects of the harm it causes. Being able to drive change through advocacy and education is the best way we as clinicians can impact not just the future of health care but provide for the daily care

of our patients who depend on and trust us to provide for their medical needs. We must be the impactors of change for ourselves, colleagues, staff, and profession if we are to really make advancements into the future.

Oh...and health insurance CEOs and their proxies, to get out of their “time-out” would still be entitled to one phone call to beg forgiveness from their mommies/daddies, priest/rabbi/pastor, psychologist/psychiatrist/mystic healer, etc., but alas, the average wait time is an hour, and if anyone answers the phone, they have a grade school education used in following an irrelevant algorithm. ●

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