Physicians, payers collaborate on prior-authorization relief

In the past, Jack Resneck Jr., MD, expected to fill out an occasional prior-authorization (PA) request if he ordered a new or unusually expensive medication or diagnostic test for his patients. But lately, he said, "the burden has grown exponentially." His practice has been inundated with requirements to submit PA forms—even for long-available generic drugs and for patients on an established medication regimen to manage a chronic condition.

"Sometimes, health plans deny reasonable prior-authorization requests for evidence-based treatments and instead send back 'suggested alternatives' that are completely inappropriate for the disease being treated," Dr. Resneck, chair-elect of the AMA Board of Trustees, told AMA Wire®. "We also now have to submit prior-auth requests for many patients who are already stable on a therapy when their health plan suddenly changes the rules."

To reverse this alarming trend, the AMA has undertaken numerous advocacy initiatives to reform prior authorization and reduce the burden on physicians and patients. Among these is the recent release of a consensus statement (PDF) between the AMA, the insurance industry trade group America's Health Insurance Plans (AHIP), the Blue Cross/Blue Shield Association and other stakeholder organizations announcing their commitment to improving the prior-authorization process.

"I hope that this consensus statement, in combination with other actions we are taking, will help move us in the right direction to reduce the growing burden of prior authorizations," said Dr. Resneck, a health policy expert and professor of dermatology at the University of California, San Francisco. "The growing time spent on prior authorization for appropriate drugs and procedures is consuming hours that we would rather spend with our patients."

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