Moving Medicine

"I’m used to my patients’ prior auth hassles. Then came Mom’s." Gerald Harmon, MD, shares a personal story

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Excessive prior authorization processes pose a significant obstacle to the quality of care our patients need and deserve. In this episode of Moving Medicine, AMA Immediate Past President, Gerald E. Harmon, MD, shares his frustration handling his mother's prior authorization as well as some strategies to navigate prior auth.

Speaker

- Gerald Harmon, MD, immediate past president, AMA

Host

- Todd Unger, chief experience officer, American Medical Association

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Transcript

Dr. Harmon: "We as doctors get so frustrated when we recommend, when we know a therapy, when we know what a patient needs and we know we need to have a diagnosis to help us get them that need met and yet we run into an administrative economic barrier that is not anticipated."


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Unger: That was AMA Immediate Past President, Dr. Gerald Harmon. In this episode of Moving Medicine, he shares his personal story of handling a prior authorization request for his mother’s medication.

**Dr. Harmon:** From someone in the trenches, both as a caregiver for my mom, as an advocate for her and as a frontline physician provider, it's an ongoing battle. I fear that we're losing it. Some of our data points indicate that as many as 80% of patients will just abandon the recommended treatment. Whether it's a prescription, whether it's an imaging study, whether it's a procedure, they'll give up because of their frustrations and or the cost or the delay in access to care. Now the doctors continue to advocate for them but the patient is the one who has to pay the price and that's so frustrating for us in health care.

Unger: Dr. Harmon also shares his strategies for navigating the system to improve care for his patients. Here's Dr. Gerald Harmon.

**Dr. Harmon:** I've had my own personal tribulations and experiences with the challenges of prior authorization. My mom is 92. She's in an assisted living facility and is very well cared for there, and it's been very stable. She has a couple of medical issues and because of her insurance coverage having changed at the request and the mandate of her insurance carrier—the first of this calendar year, I found myself the recipient of a request to obtain prior authorization for her medications, even though she'd been stable on them for the better part of a decade. Mom is 92. She has high blood pressure. She has memory challenges. She has a history of thromboembolic disease and on a number of medications that are quite important and required for her day-to-day safety and health.

I got a phone call from her nurses at the facility. And they said, "Dr. Harmon, we need you to handle her medication requirements because we've gotten notice from her insurance coverage that we're going to have to contact them before they continue the medications." And I'm thinking, "Well, that was very frustrating for me." But I got the data. I have power of attorney from my mom. I called the insurance coverage person.

They said, "Well, we have a new Medicare Advantage Plan for your mom and it requires prior authorization for these medications. And I said, "She's been stable on these medicines for the better part of a decade. She has substantial medical issues. She's had to be hospitalized before when her medicines aren't right. I'd like for her to continue. And I believe they're all generic medicines with exception of one brand name. So, they're relatively inexpensive compared to what they might be. Can we just not continue that?" "Oh no, we're not allowed to continue. They must be prior authorized." And I said, "Well, all right. This is going to be a very complicated process but I'll do this."

I had to then reach out to the pharmacies and had to reach out to her family medicine doctor and we had to go through a substantial amount of effort. It's so frustrating. It was so frustrating for me to deal
with this because not everybody has a physician son or a physician power of attorney holder, or nurse or a health care specialist. Not everybody has the president of the AMA as her son or daughter to be able to intervene on this behalf. And of course, I never talked to any of the prior authorization team about me being a physician or about me being president of the AMA, because that's not germane to the topic. The topic was to get my mom's medications continued safely.

I found myself using the argument that if she's stable now and we cause interruption in her care, then she's at high risk. "Don't you have some boundaries that allow you to make exceptions?" "No, we're not allowed to have exceptions." And I said, "Well, goodness gracious. Can I do anything from my end?" "No, you just need to know, we need to have the doctor call us and talk to it." Number one, it took me 30 minutes on hold to get through to somebody because I had to dial an 800 number. Thank goodness it was an admin day when I could sit at my desk and do that and put the phone on speaker phone. And then I had all the insurance papers and everything in front of me, so I could talk intelligently about it.

They were very polite, I will tell you, but they were very adamant and they were very structured in their answers. I had no recourse except to turn this information over to her health care provider, her doctor, and he was very pleasant about it. We know from personal experience and we know from our data, that it takes the average doctor two weekdays, two workdays every week to handle prior authorizations in his or her practice. On average about 40 a week by the average doctor in America. This puts these 92-year-olds at substantial risk. It put my mom at substantial risk. These are generic medications, she's stable on them. They were going to even ask us to do what's called step therapy, which means start at the bottom dosing and or an alternative to work towards these very economically, already advantageous very stable medications but there was no rhyme nor reason available to this. I cannot imagine the burden that the average patient and or the caregiver runs into if they don't know some of the nuances of this. Of course, nuances didn't help. It was so structured. There was just only one way to fill in the dots to connect the dots. This is not a safe way. I would use the term, this ain't a way to run a railroad. It just isn't. The trains are going to collide. Clearly. I just cannot imagine how the average 92-year-old or 75-year-old can do this. I'll tell you it's not just my mom. Of course, that was my personal frustration as a provider; I run into this all the time. What's interesting as a provider is I'll get phone calls from my patients, not from the insurance companies. It's always a patient who is bearing the burden of the administrative delay.

They didn't call my mom's doctor. They, meaning the insurance company, or the prior authorization of pharmacy benefit manager, they called the nurse delivering the care of the patient. Of course, mom didn't know what to do with this. She gets a phone call and the nurse says, "You've got a call." The first touch point is not the prescriber or the health care professional, it's the patient who was bombarded with this litany of paperwork of regulations and said, "You've got to do this. Your doctor's got to do this." Of course, the patient says, "Well, why ain't Dr. Harmon doing this? Why ain't Dr. X
doing this? Aren't they doing their job?” They start having a little bit of loss of confidence in the doctor.

Just last week I got a phone call from a patient of mine that's been my patient for 35 years. He's stable as a type two diabetic. He's been stable on this current SGLT2 inhibitor. And he says, "Gerry, you've got to call a pharmacy benefit manager to continue my medications that I'm stable on. They're only going to give me 30 more days and I'm going to run out of medicine. So you've got to call him." They didn't bother calling me to give me a heads up that I've got the patient running out of medicine and they want me to change his medication, this SGLT2 inhibitor he's very stable, to a totally different one, that they won't even cover the current one that he's on. They've changed his formulary without his knowledge or without my knowledge.

I've already tried a couple of times to call him and get through to him but I haven't been able to do it. This is so typical of the benefit managers and prior authorization process. It's all about economics for the insurance company, economics for the benefit managers but not for health care and safety of the patient. It's so frustrating to me. Of course, the patients assumes that I'm in charge of all this. I really would like to be but I'm not empowered to be until I talk to someone on the phone to try to change their mind about my rationale.

Frequently, in some of our benefit manager prior authorization discussions, I'm not allowed the opportunity to have a peer-to-peer relationship. So, I can't talk to a health care professional. I have to talk to someone who's reading from a script, who's reading from a checklist, who looks it up in the book, who says, "Dr. Harmon, this is all we're allowed to do. We have the following choices, you can do this. And we only approve these following benefits." Occasionally I get to talk to a pharmacist, which is a real relief to talk to someone with clinical training. But really talking to a peer-to-peer would be my ultimate goal because I think I convince them of the position from my perspective and what I'm doing for the patient and why the alternatives they may suggest would not be appropriate nor safe.

That's the trials and tribulations of the prior authorization process from the frontline reporter. From someone in the trenches, both as a caregiver for my mom, as an advocate for her, and as a frontline physician provider, it's an ongoing battle. I fear that we're losing it. Some of our data points indicate that as many as 80% of patients will just abandon the recommended treatment. Whether it's a prescription, whether it's an imaging study, whether it's a procedure, they'll give up because of their frustrations and or the cost or the delay in access to care. Now the doctors continue to advocate for them but the patient is the one who has to pay the price and that's so frustrating for us in health care.

We can have lots of policy and thought process where we don't want, let's say the legislature, politicians and regulators in the physician-patient relationship. We sure don't want an insurance company and/or someone whose only interest is economic benefit to determine the medications and the type of medications and timing of medications for patients. That's so frustrating.
It also frustrates me as a physician at a broader plane that as far as I can tell the rationale for this is not clinical. It is apparently just economic and it's economic pressures for the payers, in my opinion. And that's what's frustrating. In my mom's episode, I can tell you that if there's any cost savings because of anything they're doing economically, surely not pass along to the patient. Her medications, her co-payments and her deductibles go up every year. So, I don't see any economic benefits to her as a patient, nor to me as a caregiver for her. So that also is a little bit of friction.

Now with regard to the fact that the insurance companies and or the benefit managers typically don't reach out to the providers or the doctors, that's also a standard operating procedure in my experience. The first time I usually hear about the need to change medications is from the patient who calls my office, leaves a voicemail, leaves a message on my phone or sends me an email and says, "Dr. Harmon, you've got to do something about my medications. The insurance company tells me they've sent you several messages and you haven't responded, and I'm in my last two weeks of prescriptions and I can't get a refill without you calling them and renewing my prescription." This is the messaging that my patient is getting from the insurance company and or the benefit manager, that Dr. Harmon's not responding. Dr. Harmon is not doing his or her job.

They know me but they're calling me not in an accusatory, but, "Hey, they're besmirching your reputation. They're thinking you're not doing your job. I know you better than that. What can I do to help?" Unfortunately for the patient, they really can't do anything either. They've already got a contract, certainly in the Medicare Advantage Plan. There's a re-authorization or certification period but it closes out. So, you can't go back and change your insurance plan after the end date. So, they're kind of stuck in this marriage until another year before they can annul it or go forward. So, it's real frustrating for them.

They can't change their insurance company. They surely can't change their benefit manager. They didn't have any input. They don't even know what a prior authorization is until they can't get their prescriptions and they only have two weeks left. It is so challenging there. I'll tell you, we as doctors, we shouldn't have to defend the insurance companies to our patients, which we find up doing. I do explain to them that the insurance company should let me know and the benefit manager needs to do it but I also explain that it is the bane of my existence.

I use the statistic of two workdays a week for the average doctor trying to do all this paperwork. Let me tell you an example that I also have, if I'm trying to do a prior authorization, sometimes my nurse or my medical technician or myself, depending on who's got the most time available, we'll find that we have to call for a prior authorization and we can't do it electronically. We actually have to call on the phone. The old-fashioned telephone.

We have to call an 800 number or some number, and then we have to give them all the data. We have to give them the insurance information, we have to give them the patient's date of birth, things like that. And then what they do is they give us then an authorization to fax them the information. So I've
called them to get permission to fax them a request. They can't even do it on the phone. They said, "Well here, you need to fax us all the data."

They don't have an electronic repository so I can send them the data points. I have to use what I call 20th-century technology and fax them. Basically, print up some paper and fax it to them or send them electronic fax so then they can review it at their discretion or their leisure. And then once they've got it, I've got to call them while they discuss the fax. That's another barrier and obstacle to care that's incredibly time-consuming has no value-added and it seems antithetical to trying to get prior authorization. What I really am getting is a prior authorization to get a prior authorization.

And you try to explain that to the patient, they look at me and they said, "You mean you have to do that just to get my blood pressure medicine?" "Oh yeah Bob, I have to do that just to get your blood pressure medicine." "Or my diabetes medicine?" "Yep, that's what I have to do Bob." It is so frustrating. "Well, you know I'm doing pretty good on this diabetes medicine." "Yeah, you really are. Your A1C is below 70, right where I want it to be, and they want me to change you to a different medication because this current medication is not covered on their new formulary." "Well, nobody told me that."

"Well no, they didn't. And they certainly didn't ask me before you changed your plan or before they changed their formulary. They just do it for economic reasons. All medications are not equivalent, all people are not equivalent. What your body's responding to now is a result of some time and effort and you and I working together on your diet and your activity. And now we're putting your health care at risk while they do an administrative change." That's where I think a lot of doctors just throw their hands up with the benefits manager and the prior authorization process. To me, the economic cost of this is sometimes immeasurable. You really can't put it in too many words. But we do know that while this patient and these patients ... The one I'll call Bob, called me the other day about his medication needing to be changed because it was not on this new benefit. He's still working. He's on Medicare. He's early 70's but he's still working. He's having to spend a substantial amount of his time dealing with this pharmacy benefit manager and the insurance coverage for his formulary. He's having to reach out to me and wait for me to call him back and my nurse to try to call him back.

We're scrambling to keep him healthy because now he's only got two weeks of medication. So I'm having him come by the office, get some samples of a new medication while I'm still trying to argue that he doesn't need to be changing this. If he's going to have to change it before I can give him 90 days of a medication, I'm going to have to do my own internal step therapy to make sure he's getting his medication and safely, and not putting his health care at risk. So, he's taking time away from his job, his work and that's lost time that no one's paying for. So, there's an economic loss to him as a business.

I don't think the employers understand the lost revenue cost and lost opportunity cost to their employees who are each having their own issues with their benefit managers, for loan prescriptions.
Whether it's for blood pressure, diabetes, behavior modification, arthritis type medicines, indigestion, the GI medicines, all the plethora of medications that we deal with physicians, especially in founding medicine and primary care, a lot of lost opportunity costs where people are having to deal with the administrative hassle of continuing a stable medical regimen.

That's a huge economic loss. Basically, is underwritten by the employers who lose it in efficiency and productivity among their workers. The insurance companies just continue to take the premiums and in good faith, the employer pays those premiums and/or the employee has it deducted from his or her paycheck expecting that this type of administrative hassle would never interfere with their health and their health care.

Because of prior authorization delays, not only is the patient frustrated and then the doctor frustrated in having to take time changing his or her medications, there's a substantial health care risk. And it has occurred in my practice where folks, while we're adjusting their blood pressure medications, they wind up having to go to the emergency room. And on some occasions, they've had uncontrolled blood pressure and/or over-controlled blood pressure, either high or low, both of which can cause them to fall, both of which can cause them a neurologic event, both of which can contribute to injury from doing that. I had a patient earlier this year that had an episode of continued dizziness. And he had seen my partner, seen various doctors in the community and he had some uncoordination problems. He was having some difficulty, believe it or not, playing golf. He was having some troubles when he'd been over, he was a little dizzy. When he was walking on the golf course, he'd be a little bit asymmetric in his walking. And he had been to some doctors. He does have diabetes and they thought it might be related to his diabetes and/or his blood pressure. But one of the things I thought about, he was also having a little bit of challenge cognitively, was maybe he could have something called normal pressure hydrocephalus, which is a kind of an atypical neurologic condition that's kind of uncommon. The best way to look at this sometimes is with an MRI.

Since it's affecting his balance, I also want to look at the bottom part of his brain called the cerebellum or the lower part of the brain, which is where your balance center is in your body. And the ordinary CT imaging or CAT scans only pick up the midbrain up. They don't really pick up the midbrain down and the balance centers may not be affected. He had a CT of his head that was benign for his age. And I wanted to get a more extensive look at his lower brain to look at what's going on there that would affect his balance center. He has a Medicare Advantage Plan and the Medicare Advantage benefit manager denied the MRI that I'd ordered. And let me tell you, when we do an MRI, there's not a lot of radiation. That's one of the benefits of Magnetic Resident Imaging.

It doesn't use a lot of contrast, if any. It doesn't use a lot of radiation. It is a magnet. So the benefit manager's rationale in my opinion as a clinician for restricting access to an MRI is economic only. It's not like there's an appropriate use criteria as much for magnetic resonance as there is for CT scans, which have a lot of dye and more radiation. It can have substantial radiation-induced injuries should
you pile up a number of radiologic procedures on someone inappropriately. So to me, this is an economic barrier only for clinical care. I had to argue with them substantially. I spent about 20 to 30 minutes discussing with their benefit manager and their rationale for me doing the MRI.

And it took me a week with a couple of phone calls, faxing, faxing again, the documentation of what had happened before that radiology imaging procedure was approved for that colleague. And sure enough, he had a normal pressure hydrocephalus, which can be a surgical disease. I called up a neurosurgeon colleague of mine. He said, "Yeah, you did the right thing getting a MRI. It looks like him. Let's work him up for a procedure." He's in the process of getting that done now. But that delay in care while it didn't necessarily put him at a substantial risk immediately, he could have fallen. He's 70, he's trying to be active on the golf course. He could have injured himself.

And the delay in care was only economic, in my opinion. The delay in diagnosis was only economic. With the diagnosis being delayed then we had to delay his care because we weren't sure what to treat him with. This is so continuing. It's such a continual barrier that in frustration to doctors and to patients when a doctor that they trust recommends a procedure and/or a study or a medication, and they find that the folks that they've paid premiums to provide coverage, and I think has been marketed to them very slickly that we've got your coverage, we've got a broad base. You've got all the care you need. We have neurosurgical, we have pharmacologic coverage, we have x-ray coverage. If you need care, it's in our network. But then when they put those barriers up, it's not so fast.

We as doctors get so frustrated when we recommend, when we know a therapy, when we know what a patient needs and we know we need to have a diagnosis to help us get them that need met and yet we run into an administrative economic barrier that is not anticipated. It frustrates us immensely. And that's one of the, I guess, the burnout stimulus problems that I find in young doctors and even older doctors. They get kind of tired of fighting against the system on behalf of their patients.

They know what's best. They've got the training and experience. They have no economic incentive for themselves. It's not like I own an MRI unit or I have an imaging center or I have a pharmacy. I just know what my patient needs. And so I'm doing it with an independent approach. I'm doing it because it's best for the patient. And when I get these barriers thrown up, it really kind of wears on me and my frustration grows. But one of the things I have to do is stay focused. I really have to stay focused and have to continue to bulldog that approach to get my patient care. That wears a lot of doctors. They get incredibly frustrated. The patients are delayed in care. And that's why I think we know the statistics that show as many as 80% of patients just basically give up. It's just they wear them down. They wear us down sometimes. They, meaning the barrier erectors as it were, the benefit managers and the insurance companies and their narrow networks.

Within my medical practice, within our group of family medicine specialists that I work with, we have a team-based approach to responding to the prior benefit, prior authorization handling. It's not one person because really, it becomes a team approach. We sometimes use our medical assistants. We
use our nursing assistants. We use LPNs, RNs. Many times, we find that the physician is probably the most efficient weapon system to use against it. So, what we wind up doing is I'll ask my nurse, Lisa, and I'll say, "Lisa, would you try to get all the data together on Mr. Martin or Mr. Jones or Mrs. Smith's suggestions or needs. And then we'll gather the data so that I have the numbers in my hand. And then if you'll make the phone call, and I know you can do this while I'm doing patient care." And we'll have a type of phone line, unfortunately. We'll call the 800 number, whatever we're provided, to start working on this because there's no electronic format. There's no standardized electronic format.

We've advocated for that for years now, the AMA, to have a standardized electronic format and a common language so that we have a common operating picture. That doesn't exist. That's in our request and our joint statement that we came up with about four or five years ago that said, this needs to be done. We haven't had a lot of progress done on that either. But then I'll have my medical assistant get them on the phone. And then she'll say, "Let me get Dr. Harmon real quick," and I'll come to the phone and I'll talk to them generally. It's not a clinical person, though. It is a benefit manager who's reading from a script and/or a textbook or a checklist or things like that. And I try to be very polite. I find that you get a whole lot more with sugar than you do with vinegar.

Okay, so you got to be nice. And I don't try to patronize the person on the phone and say, "Hey, thank y'all for coming." And I use my Southern dialect a little bit. Even though I might be talking to someone that's not only in my neighborhood but not only even on the continent, but at least I try to talk in a very slow, not frustrating manner. And I'll say, "Hey, I'm calling on behalf of Ms. Smith. We're trying to get her an x-ray. We're trying to get her this medication, to renew it. She's been very stable on it. What can I do to help you get your job done," is how I approach it and I talk to him about it. You can try to get that done. And if they say, "Well, Dr. Harmon, her benefit plan says this. She has to do this or you have to do this." And I'll say, "Well, do you have clinical training? Can I talk with a pharmacist or can I talk with a peer-to-peers at a request?" And on rare occasion, they'll let me do that.

On most of the times, they'll say, we'll have the peer-to-peer call you back at some convenient time and I don't know when that'll be. But that's our process. We do try our best to get it done. I will tell you that the nurse or the nursing assistant in my practice probably does get by with about 60 to 75%. They can do it but it takes them more than one phone call. It takes them more than one day. It probably takes them an hour each patient on each case, 20-minute intervals, things like that. That's my experience. And that's what my, my nursing staff, they get very frustrated too but they kind of see the way I handle it and that's what they do.

And our statistics show that 75, 80% of those that we do this across the enterprise are approved. If we can get through the barriers and talk to someone that allows us to get the approval. The way the 82% number fallout occurs is they just don't have that patience or time or they can't connect up with the right person on the other end to get the data transmitted and the job done. That's when the patients are at risk for bad outcomes or permanent injury, even death. That's when the risk occurs, when
they're delaying diagnosis and our care occurs. Again, I think what we've seen is almost overwhelmingly for economic reasons. And the economic benefit is only to the insurance company or the third party benefit manager. With regard to getting prior authorizations, whether it's an imaging study, whether it's a procedure or whether it's a medication, on rare occasion, I am denied in access to a peer-to-peer. About several months ago, I was discharging a patient after taking care of him in the hospital. I was doing a hospitalist shift. And this patient had pulmonary artery hypertension, which is an increasingly common condition where the right side of the heart is having trouble pumping blood through the lungs to get oxygen. And so the right side of the heart is struggling. You can have what's called right-sided heart failure from pulmonary artery hypertension. And there are some medical treatments. There are not a lot of surgical treatments. We're working on new treatments and technology. Thank goodness we're getting better at everything. As we see this disease progress, we're developing new treatments.

Now, there are a couple of medical treatments, prescription drugs that you can use that will benefit this type of disease. I was discharging a patient from the hospital with a medication that would treat pulmonary artery hypertension. This person was not of Medicare age. So it had a standard or community benefit manager, not a Medicare, not a federal benefit manager but it was a traditionally indemnity insurance coverage. And typically, my experience has been in a hospital, experience has been for the pharmacy. When we write a prescription that's a new medication for a patient upon discharge, we have a clinical pharmacologist or a benefit manager check a prescription out to make sure that the prescribed medication will be covered by the patient so that when they get discharged, they'll be able to go to the drug store or pharmacy and get their medicines and not have bad outcomes.

I mean, we've learned to do this. We've learned to anticipate the prior authorization process, which is, I mean, it's another unanticipated cost we bear ourselves and the health care industry. The insurance company doesn't pay for this and the pharmacy benefit managers don't. But we know in our small town hospital system that there's a chance the patient won't be able to get this medication. Even though it's a generic medicine, it should be available at a reasonable price, any barrier sometimes to care will be borne by the patient. And sometimes they don't have the economic wherewithal to even pay a $20 prescription co-pay or something like that. So we try to test it out. I found out the pharmacologist and our hospital system had tested this prescription and said, "Dr. Harmon, before Mrs. Jones goes home, we need prior authorization because this medication won't be covered on her prescription drug plan."

So I said, "Okay, good. I'm glad we caught it now versus when she got home and it came back a week later with worsening right heart failure when she said, 'I can't take my medicine.'" We don't always have the availability for them to see their doctor within 48 hours of discharge too, so I don't know what would've happened to her. Anyway, I called the pharmacy benefit manager number that was provided through our research. And I asked if we could prescribe it, told them the reasons. And they said, "Dr.
Harmon, that's not our formula. We can't give her that medication." Well, there's not a lot of alternatives. There's not a lot of alternative drugs for pulmonary artery hypertension. I said, "Listen, I really need to talk to a doctor to explain this to him. Can you allow that to happen?" "No, we don't allow that in our plan either."

So I couldn't talk to a doctor about a doctor's condition that's not so rare that the doctors won't know about it, and they understand pulmon-artery hypertension can cause pretty catastrophic outcomes. You have heart failure, you can have blood clots, you can die, you can lose consciousness, all these things. So what I did, I called a pharmacy friend of mine and I said, "Hey, this is now generic medicine, but there may still be some brand name samples. Do you think you can go through your drugs and find it?" And he's a pharmacist. He said, "Yeah, I got a month's worth. Let me go find you some." And I said, "Listen, I told the patient, 'I need to have your home address. And I'll get this delivered to you when you get home.'" She said, "Well, Dr. Harmon, you're so nice." I said, "Well, I'm just being a doctor. We got to take care of you."

I had to work till 7:00 P.M. So, I went ahead and had the pharmacy friend of mine drop them off in my office. And I said, "Put it in the laboratory samples. Nobody will pick it up." And I went by and got it and then I dropped it off at her home. But that's an extraordinary cost of care that is only borne by the doctors or the patients or the hospitals and the practices. No one pays for that. It's the economic impediment, the barrier to prior authorization sets up. And it's caused by narrow networks by lack of economic coverage and a lack of, I think, contractual obligations being met.

That's why we have legislative opportunities within the Congress that AMA is very supportive of. There is a Protecting Seniors Access to Care Act. It's in a House bill and a Senate bill, both of which is active legislation that we very much support within the AMA and other health care agencies. It has a lot of the joint concerns that we put in our manifesto together, working with the American Pharmaceutical Association, American Hospital Association, the AMA, about four years ago in 2018 or so when we said, "These are the expectations for prior authorization for meeting the needs of the patient, the expectations of the health care system and the prescriber's expectations." And this is in the Protecting Seniors Access to Care Act. It just needs to be passed. We need to hold accountable with legislation, the benefit managers and the insurance companies so that patients are not put at risk and doctors can have confidence that their recommendations for treatment, diagnosis and therapy will be followed.

We have workarounds and we work around. We run into these roadblocks delivering care. If it's a pharmacy benefits manager, if it's a narrow network, if it's a formulary, lack of coverage, we work with a lot of diligence, a lot of energy to do this. But there aren't enough doctors that have enough time. There aren't enough nurses and pharmacists that have enough time to meet the unmet needs of everybody and I find that this is where we also run into the reality of a lack of health equity, because not everybody has a country doctor near them. They don't have a hospital near them. They live a long way off from a hospital. They always have the hospital benefit managers check on their prescription
drugs when they go home.

They don't always find this out till they go to the pharmacy the next day and the pharmacist says, "Hey, I'm sorry, Mr. Brown or Mrs. Jones, this is going to cost you 200 dollars because it's not covered by your insurance." And of course, then the patient has to decide, "Do I have gasoline in my car? Do I have food for my family? Can I afford to take another week off of work while I go through this hassle or can I just say, no thanks, I can't take the medicine," and put their health at risk? This is unacceptable. We cannot continue in this unhealthy pathway for no obvious reason other than economic advantage of the health care industry, of the health insurance industry. We, as doctors, and the problem we also find with prior authorization as a physician is we don't know what we don't know. A lot of times when you're having a patient that has a complexity of medical issues, you tend to have maybe one hospitalist, one internist, one family medicine doctor in the ambulatory environment who's seeing one perspective. The complicated patient sometimes goes to three or four different medical specialists, and he or she will get advice from those three or four different medical specialists and they'll have prescriptions maybe for each disorder, maybe from the pulmonologist, maybe from the gastroenterologist, maybe from the cardiologist.

And if they have the good fortune of having a primary care medical home, then that primary care medical quarterback can sometimes help with all these complex medical prescriptions. But not everybody has access to a primary care medical home. Unfortunately, we just don't have enough of us doctors or primary care medical specialists to meet all the needs of a growing burden of chronic disease patients. So these folks are put at substantial risk when they leave their specialist, very specialist offices with prescriptions, sometimes, for life-saving or life-maintaining medications, and they get to the pharmacy and they find that they don't have coverage. It is such a high-risk environment, especially with the multiple disease, chronic disease patient that it needs to have some reform with the centralization of the prior authorization process, perhaps, say, a more highly regulated, highly integrated drug listing system, as it were.

I find one of my most complex issues in health care, in the hospitalized patient or even in my ambulatory patient is what we call medication reconciliation or med rec, and you might have a bunch of prescriptions on one list and you ask the patient, "Hey Mr. Brown or Ms. Smith or Mr. Martin, are you taking these five medications?" "I can only afford three of them, so I'm only taking three." You don't find that out till they come to the hospital or they come to your office and you find out then because they were either didn't have time or embarrassed to tell you they couldn't afford their medication. One of the methods I use as a workaround when I'm calling a prescription in or offering a new prescription for a patient is I'll ask the patient, "What pharmacy do you use?" In small-town America, it's usually one pharmacy. We know where they are. But it may be the pharmacy can be a local pharmacy, an independent pharmacy. It can be a chain pharmacy and also just we'll call the pharmacist. And I'll say, "I'm going to call about Emily or I'm going to call about Jerry or something, and I'm going to prescribe this new medication. Do you mind, when you have time, to run a claim? You
don't have to do it right now. Do it over the next hour and I'll call you back," and they'll say, "Stand by, Dr Harmon. I'll see what I can do. I have just a moment."

They'll run it and say, "Nope, it's not going to be covered." I say, "What other class of medication might be covered?" And the pharmacist and I will take our energy and our expense and assume all the risk, as it were, and we'll do that for the patient because we're dedicated. And I tell you, most doctors and most pharmacists are doing just that. Again, that's an underwritten cost that we deliver on our own nickel, as it were. So, the pharmacy benefit managers and insurance companies and the formulary developers don't even see but we will do that.

We'll run a claim just to find out what will be covered. And then it may be three times before I get a hit. I'll strike out on a couple of them, and I'll say, "Well, can you run this kind? Can you run this kind? If it's an antihypertensive, can I use a calcium blocker? Can I use an angiotensin receptor blocker?" I'll run those different types but I know that, really, I need to be in an ARB or an ACE inhibitor frame, and I'll find out which one of those particular types of medication will be covered by the formulary. Again, that's a cost we assume on our own for the benefit of the patient but that's a workaround that should not have to be there. We should have immediate transparency. In today's world of electronic records my electrons ought to access the company's electrons but the formulary, because they take enough dollars for their premiums, they ought to be able to provide that resource to the patient, to the provider and the prescriber.

When we talk about regulatory and legislative changes to the prior authorization process, we need to look at two different targets. One, of course, when we're talking about Medicare or Medicaid, the Center for Medicare and Medicaid Services sponsored coverage, then that needs to be a federal solution. There's no question. And we need to look at providing access to Seniors Care Act that we are advocating for at the AMA level. But in traditional indemnity insurance and traditional coverages, many times our better audience would be the state legislative, the state insurance industry, the regulators within each individual state and/or province. They're a better target audience because they really have authority and should, I think, have authority over what goes on within their licensees and their insurance industries within their state. And I think that's a more effective use of our resources, and I think that's where patients can find a positive audience when we take these concerns to them as physicians, as patients, as consumers. So I think that's a good idea.

When my patients come into me and they say, "I'm having trouble getting this prescription," we do have to run various claims for the insurance. It's not always our Medicare insurance or our Medicaid patients. In fact, only about 20% of my patients are Medicaid and about 25% are Medicare. So I have almost 50% traditional indemnity insurance and those folks usually operate, in fact, they always operate under the state insurance commissioners. So we can address our concerns at the legislative arena for legislative regulatory relief at the state legislators. I find that to be very receptive because this is where government being local makes a difference.
And if you can find an empathetic, not just a sympathetic legislator whose mama or whose sister whose spouse or who himself or herself has experienced regulatory delay, and again, in small-town South Carolina, I have a pretty good relationship with many of our legislators in both houses of the state legislator and in the executive office. So we can talk to them about their family member having to bear the burden of prior authorization. So they understand firsthand my issues. That's a good receptive audience because, as I said, not only are they sympathetic, they're empathetic. They've experienced the aggravation and they can talk with experience when they try to change the accountability for the insurance companies and the benefit managers at the point of care in my state. And I think that's a rich target environment for us to make regulatory change.

I think all of these things resonate when you talk about how it affected your family, how it affected you, how it affected your neighbors. It's an uphill battle. It's one that we've been continuing to contest for the better part of a decade—and since I've been on the board of AMA—it's been very frustrating for us. The target sometimes is difficult to identify but I think the prior authorization process seems to be a common tipping point. If we can get an expectation from the insurance industry, from the prior authorization process to align with our standards that we came to an agreement on four or five years ago in our common statement, that's a starting point.

I mean, that's not the endpoint but it's a starting point. If we can start in that way, we can realize how we can make changes, how we can improve health care. And in the long run, not just improve the individual health of individuals with chronic diseases or acute diseases that need long-term medications. We can reduce the burden of disease and disability and even death. So we can reduce the cost. If we can reduce that economic drain by keeping people from getting sicker and requiring more medications, requiring more medical intervention and care so that they may not need their heart replacement or heart valve replacement or knee hip replacement or joint replacement, because they've been controlled with their chronic diseases, maybe their kidney disease is not as advanced as it would've been if they had gotten on the medications, because if blood pressure had been better controlled, they wouldn't be affected by stroke, cardiovascular disease and heart attacks, then we can save us money.

We're going to have an increasing burden of disease right now. Let's have a more efficient way of delivering health care at both preventive as well as the maintenance approaches to it so that there's an economic solution that benefits all of us, not just a reduction in cost outlying from the insurance industry right now. There's no question that they have fiduciary accountability for their companies, but instead of just looking at this year's budget and this year's approval process and this year's formulary, maybe they need to look at the long-term outcome.

If we can control this long term, we can reduce the 800 million dollars or 800 billion dollars we spend on cardiovascular disease in the country right now because it's continuing to escalate. We're doing the best we can to provide better care and better treatments. But if we can reduce the disease burden,
that's another way to have a better long-term savings and deliver quality care at a fair price.

One of the approaches we can use to address prior authorization change that's needed, and we can address the barriers to care and the negative impact on health care delivery that is now imposed by prior authorization, one of the things we've done at AMA is we've understood that you're going to have to get this message out, and the need, to the regulatory agencies, to the legislatures. We have fixpriorauth.org. You can share your individual story about your mom, about your sister. If you're a provider, you can share about your patients, your neighbors, and you can tell them, "Here's what happened to me. Here's why this prior authorization caused me to have a stroke or it put me at risk for incapacitation, it made me miss a week of work, cost me time away or cost my employees." Whatever your position is relative to your story, share that story on fixpriorauth.org. It's a great website. I've been on it. I looked at it. I'll share my stories on it, and I encourage my patients to do it. I actually tell them to call the insurance commissioner. I tell them South Carolina insurance commissioner, in my state, if you call them, they're not going to hang up on you. They're going to answer your phone. They're elected politicians. They're elected government agencies. They need to know because if they don't know, they don't have data to make a decision on. So, ask them to call. I said, "You're not worrying your legislators to do this. You're not worrying your state senator, your state representative." They need to know what's going on, whether it's a broken stoplight, whether it's an unfair economic practice where somebody is doing something that we need to call about the better business bureau, something, maybe they're operating without a license. If they're doing something that's inappropriate for your health care, let them know. They have the resources; they have the accountability and the responsibility to know about this and to act upon it.

So yeah, I encourage my patients, I encourage my doctor colleagues to get involved legislatively and administratively and share their stories because storytelling is not just about anecdotes. It's about reality and it has a personal reflection that if you can identify, "That could be me. That could be my mom. That could be my neighbor or I remember when I had this prescription that I couldn't get filled because it didn't get coverage." Thank goodness I didn't have an adverse event or maybe I did. But those are ways to do it. The only way they'll know is if we tell them.

What we as doctors, what we as patients, what we as caregivers can do to impact prior authorization right now is to share our stories. Fixpriorauth.org—use that website, share your story, call your individual state legislators, let them know your concerns. Give them your stories with health care, with prior authorization. You can make a difference but they need to know about it in order for them to make a difference.

Unger: For more information on the AMA’s fight to fix prior authorization, you can visit FixPriorAuth.org and take action. You can subscribe to Moving Medicine and other great AMA podcasts anywhere you listen to yours or visit ama-assn.org/podcasts.
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