Prior Authorization Hearing Talking Points

What is prior authorization?

- Prior authorization is also known as prior auth or preauthorization.
- It is a requirement that insurers put on some drugs, treatments, and prescriptions requiring them to “approve” the drug or treatment before covering it.
- Prior auths can be for cost or medical reasons, but payers right now do not need to disclose the reasoning.

Why do we need to reform prior auth?

- Prior auths delay treatments – an insurer issuing a prior auth means the patient cannot use that prescription or treatment until it is approved by the insurer.
- Insurers do not need to disclose reasons or data behind prior auths – they can do so and not publicly share who is doing the review or share data.
- Insurers do not see the patients in person – they make these decisions looking at numbers and demographic data, not the person needing the treatment.
- Who is better to decide treatment for a patient – the patient’s doctor who sees and talks to the patient, or a corporate suit located outside of DC who’s never met the person?

Data on prior auths from the AMA 2021 national physician survey

- 93% of physicians reported care delays because of prior authorizations.
- 82% of physicians reported prior auths can lead to treatment abandonment.
- 34% of physicians reported that prior auth has led to a serious adverse event for their patients.
- Physicians and their staff spend an average of 13 hours/week on prior auths.
- Physicians complete an average of 41 prior auths per week.
- 40% of physicians have staff who work exclusively on prior auth.

Why B25-124?

- Ensures any prior authorizations are issued for legitimate medical reasons and not to save insurers money.
- Allows patients to stay on their prescriptions for a time after insurance changes.
- Ensures locally licensed appropriate medical personnel are issuing prior authorizations and reviewing appeals.
- Requires very clear criteria from insurers when and where they issue prior authorizations.