



Prior Authorization: Impact on Patients with Rheumatologic Disorders

*A Survey of Rheumatologists
by the Coalition of State Rheumatology Organizations*

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I. Survey Overview and Methodology:

In June of 2011, the Coalition of State Rheumatology Organizations (CSRO) issued a survey to measure rheumatologists' perceptions and experiences with prior authorization and step therapy, also known as fail-first, protocols.

The goals of the survey were to:

- Determine whether concerns about prior authorization and fail-first protocols are universal or isolated to certain pockets of the rheumatology community; and
- Understand how such requirements impact patient care, practice management and professional satisfaction.

CSRO used a web-based survey tool to distribute a 14-question survey to rheumatologists nationwide. Questions were designed to measure physician perceptions about four specific areas potentially affected by prior authorization, pre-certification and step-therapy requirements: The ability to provide quality care; physician and staff time necessary to meet requirements; quality of communication between payers and providers; and impact on physician job satisfaction.

The survey was distributed through state and regional CSRO member organizations to approximately 600 rheumatologists nationwide. It received 195 responses, a response rate of 30 percent.

II. Issue Background:

Prior authorization – also known as pre-authorization, pre-certification or prior notification – is an extra set of steps some insurance carriers require before determining whether they will pay for a medical service or prescription medication. The physician, or other medical provider, is required to obtain approval from the insurance carrier before the carrier will agree to cover the cost of the medical service or prescription medication.

Step therapy, also referred to as “fail-first,” requires patients to “fail” on one or more less costly medications before the health insurance carrier will agree to

cover a more expensive medication, even if a physician thinks it as a better option for a particular patient. Some carriers have been known to require patients to fail on up to five medications before agreeing to cover the medication preferred by the patient's own doctor.

Currently, prior authorization and fail-first protocols are primarily paper based, and non-standardized. Each insurance carrier has its own set of requirements, which can vary among plans, even within the same carrier's portfolio of coverage options. To meet prior authorization requirements physicians must complete a time-consuming series of faxes, phone calls, emails, input of data into insurance carrier Web sites and, in some cases, letters.

Because prior authorization and fail-first requirements are not standardized, and because transparency about criteria for meeting requirements is inconsistent, providers often contact payers to obtain prior authorization even when it is not necessary. In a 2010 survey of 2,400 members of the American Medical Association, 64% of physicians surveyed said it was difficult for them to know which tests and procedures require prior authorization.

Physicians are responsible for the administrative costs associated with meeting prior authorization and fail-first requirements, including direct costs to cover staff time, and hidden costs, such as time and resources diverted from patient care.

Fueled by the HITECH Act of 2009, states are moving forward with the implementation of health information technology, including electronic prescribing platforms. Electronic platforms will pervasively change how patient data is managed. This can go one of two ways for patients. The digitization of patient information could improve access to timely, affordable care, or it could create an opportunity for payers to leverage technology to continue their long-standing pattern of interfering with patient care.

III. Findings:

Impact on Patient Care

Nearly 99% of respondents say they have had to alter treatment plans – including changing prescription medications – to accommodate restrictions imposed by patient health insurance carriers.

Rheumatologists' concern over prior authorization appears to be widespread; with 91.5% of survey respondents saying prior authorization has a “*negative*” to “*very negative*” effect on their ability to treat patients. Similarly, 88.4% say pre-certification requirements have a “*negative*” to “*very negative*” effect. Eighty-nine percent say fail-first protocols have a “*negative*” to “*very negative*” effect.

Finally, 68% of respondents say insurers “*frequently*” delay or deny diagnostic testing or prescription medications for their patients. An additional 30% say testing and prescription medications are “*occasionally*” delayed or denied.

Transparency and Availability of Current Criteria

Transparency is a significant concern among practicing rheumatologists. Nearly 73% say they are only “*sometimes*” or “*rarely*” able to easily determine what procedures will be covered by a patient’s health plan at point-of-service; and 72.2% say they are only “*sometimes*” or “*rarely*” able to tell what prescription medications are available through a plan’s formulary at point-of-service.

The availability and quality of information about pre-approval criteria is of concern to rheumatologists. More than half (58.3%) of respondents say they are only “*sometimes*” or “*rarely*” able to easily determine what procedures require “pre-approval,” and the same number, 58.3%, say they are only “*sometimes*” or “*rarely*” able to easily determine what prescription medications require “pre-approval.”

Nearly 98% of respondents agree that decisions about what medications are best for a patient should be made by the patient’s own health care provider and not by the health plan or insurance company. Eighty-five percent say they “*rarely*” or “*never*” trust insurance companies to “do what is right for patients, without making cost a primary consideration.”

Impact on Career Satisfaction

Nearly 32% of respondents say they interact with patient insurance carriers between 61 and 100 times per month to obtain approval for prescription medications and procedures or to determine protocols for prior authorization and fail-first protocols. An additional 34.2% say they interact with carriers more than 100 times per month regarding such issues.

To avoid or minimize the administrative work associated with insurance protocols, 52.2% of respondents say they have considered re-establishing their practices as fee-for-service only. In other words, they would no longer accept insurance. Indeed, in an open-ended section of the survey, several rheumatologists reported that they are considering – or have already – severed relationships with particularly restrictive insurance carriers.

Nearly 22% of respondents say they have considered leaving the practice of medicine altogether; and 37.1% say they have considered retiring early.

Policy Implications

Nearly 97% of respondents agree, “There should be enforceable legislation to regulate restrictions that insurance companies place on health care providers in regards to treatment modalities they prescribe for their patients.”

IV. Conclusions:

The environment of chaos created by prior authorization requirements and fail-first protocols is costly; hinders patient access to timely, affordable, medically appropriate care; and erodes physician career satisfaction.

Prior authorization requirements and fail-first protocols strip rheumatologists of the ability to direct the most appropriate courses of treatment for individual patients. Virtually every rheumatologist responding to this survey says insurer restrictions at times supersede personal medical expertise and individual patient needs. Similarly, nearly every physician responding to the survey says prior authorization and fail-first protocols have caused their patients to suffer delays or outright denials in care.

Such practices rob patients with rheumatologic disorders of access to the kind of individualized treatment plans that can restore, enhance and preserve quality-of-life over time. Patients who receive personalized care under the direction of their own rheumatologists are less likely to require complex, costly medical care in the long-term, and are more likely to be productive members of society.

Physicians are responsible for the administrative costs associated with meeting prior authorization and fail-first requirements. These hefty administrative costs consume fiscal resources better allocated directly to patient care.

Left unchecked, prior authorization and fail-first protocols may drive some rheumatologists to abandon the profession, and discourage others from joining, leaving patients with rheumatologic disorders stranded without access to suitable care.

V. Recommendations:

Prior authorization should be standardized. Improvements in the current paper-based process can be made now through the adoption of a universal prior authorization form. Such a form is already in use in other states including Minnesota.

Payers should not be permitted to cause harmful delays in care by using fail-first protocols, which restrict the physician's ability to make the most medically appropriate treatment decisions for individual patients in a timely fashion.

Looking ahead, electronic prior authorization has the potential to benefit patients with rheumatologic disorders, but only if insurers are not permitted to leverage health information technology to create new barriers to care.

As states move forward into the electronic age of patient care, policymakers should take measures to improve and expedite the prior authorization process by ensuring that:

- Electronic prescribing platforms are provided on neutral and open platforms that do not advance the commercial interests of any particular participant (e.g., health insurers, hospitals, pharmacy benefits managers, pharmaceutical companies, etc.) to the potential detriment of the patient;
- All electronic prescribing platforms include the capability to process prior authorizations electronically;
- Electronic prior authorization requirements are streamlined and standardized;
- Adjudication of prior authorization requests occurs within a reasonable time frame (hours as opposed to days or weeks);
- Electronic prescribing platforms include access to information about all FDA-approved medications and medical services without restrictions; and,
- Complete, up-to-date information about prior authorization and fail-first criteria is available through electronic prescribing platforms at point-of-service.

VI. About Rheumatology:

Rheumatologists are internists or pediatricians who are qualified by additional training and experience in the diagnosis and treatment of arthritis and other diseases of the joints, muscles and bones. Rheumatologists treat arthritis, certain autoimmune disorders, musculoskeletal pain disorders and osteoporosis. There are more than 100 types of rheumatologic diseases, including rheumatoid arthritis, osteoarthritis, gout, lupus, back pain, fibromyalgia, and tendonitis.

Many rheumatologic diseases are very serious and complex. They can be difficult to diagnose and treat. Many can change or evolve over time. Specialized care from a rheumatologist can reduce the severity of disease and save time and money. Prompt diagnosis and specially tailored treatment can improve quality-of-life and long-term outcomes.

VII. About Coalition of State Rheumatology Organizations (CSRO)

The Coalition of State Rheumatology Organizations (CSRO) is a group of state and regional professional rheumatology societies formed in order to serve practicing rheumatologists nationwide. CSRO advocates for excellence in rheumatologic disease care and patient access to the highest quality care for the management of rheumatologic and musculoskeletal diseases.




1. Have you ever had to change the way you treat a patient, including changing prescription medications, due to restrictions imposed by an insurance company?

		Response Percent	Response Count
Yes		99.0%	189
No		1.0%	2
answered question			191
skipped question			5

2. What effect do the following insurance requirements have on your ability to treat patients?

	Very positive effect	Somewhat positive effect	No effect at all	Small negative effect	Very negative effect	Don't know	Response Count
Prior authorizations	3.7% (7)	2.1% (4)	2.1% (4)	23.7% (45)	67.9% (129)	0.5% (1)	190
Pre-certifications	3.7% (7)	2.6% (5)	2.6% (5)	29.5% (56)	58.9% (112)	2.6% (5)	190
Step therapy (also called fail-first) protocols	3.2% (6)	1.6% (3)	3.2% (6)	23.2% (44)	66.3% (126)	2.6% (5)	190
answered question							191
skipped question							5

3. In your experience, how often do you feel that insurance companies delay or deny diagnostic testing or prescription medications for your patients?

		Response Percent	Response Count
Frequently		68.1%	128
Occasionally		29.8%	56
Rarely		2.1%	4
Never		0.0%	0
answered question			188
skipped question			8

4. When writing a prescription or ordering a procedure, how often is there transparency indicating which procedures or drugs are available, or will require pre-approval?

	Always	Often	Sometimes	Rarely	Never	Response Count
procedure available	3.2% (6)	16.0% (30)	36.7% (69)	36.2% (68)	8.0% (15)	188
drug available	4.8% (9)	15.4% (29)	39.4% (74)	33.0% (62)	7.4% (14)	188
procedure requires pre-approval	4.3% (8)	30.1% (56)	29.0% (54)	29.6% (55)	7.0% (13)	186
drug requires pre-approval	5.4% (10)	30.6% (57)	28.5% (53)	29.6% (55)	5.9% (11)	186
answered question						188
skipped question						8



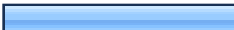
5. Approximately how many times per month are you or your staff required to interact (phone or fax) with an insurance provider to obtain approval (of a prescription or procedure) or to determine protocols (such as prior authorization or step therapy protocols)?

		Response Percent	Response Count
Less than 5		0.0%	0
5-20		9.6%	18
21-60		25.0%	47
61-100		31.4%	59
101-150		16.5%	31
More than 150		17.6%	33
answered question			188
skipped question			8







6. Do you agree or disagree with this statement? “Decisions on what medications are right for a patient should be made by the patient’s own health care provider and not by the health plan or insurance company?”

		Response Percent	Response Count
Agree		97.9%	183
Disagree		2.1%	4
answered question			187
skipped question			9




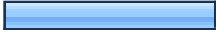

7. How often do you trust insurance companies to do what is right for patient care, without making cost a primary consideration?

		Response Percent	Response Count
Always		0.0%	0
Sometimes		14.9%	28
Rarely		50.5%	95
Never		34.6%	65
		answered question	188
		skipped question	8

8. Have you ever given serious consideration to any of the following actions to avoid or minimize the administrative work associated with insurance protocols such as pre-approval, step therapy, or other insurance practices? (Check all that apply)

		Response Percent	Response Count
No, I have never seriously considered changing my practice in response to my patients health insurance requirements		37.4%	67
Yes, I have considered moving my practice to another state		6.7%	12
Yes, I have considered changing specialties		2.8%	5
Yes, I have considered leaving the profession all together		21.8%	39
Yes, I have considered retiring early.		36.9%	66
Yes, I have considered reestablishing my practice as fee-for service only (no longer accepting insurance)		52.0%	93
	Other (please specify)		21
		answered question	179
		skipped question	17



9. Please indicate how often you e-prescribe, meaning electronically sending your prescriptions to the pharmacy?

		Response Percent	Response Count
Never		19.8%	37
Rarely		5.9%	11
Sometimes		13.9%	26
Often		31.6%	59
Always		28.9%	54
answered question			187
skipped question			9





10. Is there anything else to share about your experience with insurance requirements such as pre-approval, or step therapy protocols?

	Response Count
	72
answered question	72
skipped question	124



11. Please indicate the field that best describes your area of practice.

		Response Percent	Response Count
Rheumatology		97.3%	179
Multi-specialty		2.7%	5
answered question			184
skipped question			12

12. Please indicate how many years you have been in practice.

		Response Percent	Response Count
Less than 5		9.2%	17
Five to 10		11.9%	22
Eleven to 20		29.2%	54
More than 20		49.7%	92
answered question			185
skipped question			11

13. Do you agree or disagree with this statement, “There should be enforceable legislation to regulate restrictions that insurance companies place on health care providers in regards to treatment modalities they prescribe for their patients.”

		Response Percent	Response Count
Agree		96.7%	178
Disagree		3.3%	6
answered question			184
skipped question			12

14. Are you interested in speaking further with CSRO around advocacy/legislative priorities around the impact of insurance protocols? If yes, please provide your name, phone number, and email.

	Response Count
	40
answered question	40
skipped question	156