The Price of Prior Authorization

Estrogen. Collagenase. FSH. Mirabegron. Solifenacin succinate. Darifenacin. Sildenafil, tadalfil, vardenafil... A rogues’ gallery of urologic medications, all with variable requirements for prior authorization from insurance companies. Prescription medications represent approximately 10% of total health care spending, and there is little question that abuses occurred in the past with prescriptions, procedures, and other services. Private insurance companies impose formulary restrictions with the intention of promoting more efficient utilization and more judicious use of medications. This is an increasingly prevalent issue because formularies continue to contract and restrict coverage for specialty medications, such as growth hormone, without a clear vision for the impact this has on specific subpopulations of patients.

The Affordable Care Act (ACA) (111th United States Congress, 2010) has created opportunities for increasing numbers of people to seek routine medical care, while challenging providers to maintain or improve the quality of that care. In the past 18 to 24 months, requirements for prior authorization for medications have steadily increased. This may represent attempts by insurance companies, in the unstable environment of the ACA, to defray costs, prevent abuse, and encourage compliance with particular classes of medications. It can encourage medication adherence by keeping copayments lower. But it also represents attempts by insurance companies to “make sure patients are being managed correctly” (as I have been told over the phone). Are there unintended consequences of this shift?

Undiscovered Country

There is little information about the effects of prior authorization in peer-reviewed literature, and none at all in the nursing literature. A literature search on this topic was surprisingly sparse, and none of the available articles are focused specifically on urology. However, a general Google search for “medication prior authorization” yielded 8,730,000 hits that were overwhelmingly directed toward patients. Shah, Tongbram, and Paly (2014) reviewed the literature from 2009 forward, and revealed only 14 studies that assessed the impact of prior authorization on health care utilization and costs. They found most of the studies involved Medicaid plans, and most of these 14 studies looked at mental health medications. While the results demonstrated decreased costs and decreased pharmacy utilization, several of the included studies questioned quality of life outcomes and raised patient safety issues.

Happe, Clark, Holliday, and Young (2014) published a systematic review of the literature examining the relationship of managed care formulary restrictions to medication adherence, outcomes, health care utilization, and economic outcomes. Their analysis showed in the majority of the 93 articles, which were examined for 262 separate outcome measures, reported negative outcomes (49.6%), and that 68.3% of medication adherence outcomes alone were negative. Utilization outcomes were not associated with formulary restrictions for 50% of the outcome measures. This suggests no association between economic measures and formulary restrictions, but is subject to variability among the measures in the literature itself. Yet these authors acknowledged that “prior authorization” was the subject of only 20 of the 93 articles reviewed.

What is conspicuously absent from this sparse body of literature is the influence or burden of prior authorization on providers, with only two papers to date addressing this. Morra et al. (2011) reported an estimated $82,975 per U.S. physician FTE per year spent on interacting with insurance payers, with only $22,205 spent per physician year in Canada, with its single-payor system. These authors reported that for these primary care practices, an average of 20.6 hours was spent per week, per physician, by support staff (including nursing staff) interacting with health plans. A separate study by Morley, Badolato, Hickner, and Epling (2013) showed a much different result, with costs ranging from $2,161 to $3,430 per physician. These authors acknowledged that this cost estimate did not
include an estimate for lost productivity, issues relative to lost opportunities to see other patients, or issues relative to operational efficiency of the practice. This may offer an explanation for the lower estimate. Both studies are subject to recall bias and were not direct observation studies. Nonetheless, these studies acknowledged they were not designed to capture denying treatment or delays in patient treatment and did not include an estimate for the level of frustration experienced by physicians or patients.

Collateral Damage

This “state of the science” regarding the role of prior authorization in patient outcomes offers only a vague reflection of its impact on patient care. There are additional questions when any discussion about prior authorization is advanced. For example, there is no estimate published to date addressing any savings associated with formulary compliance compared with savings generated by avoiding potential inappropriate care. There are suggestions about the burden of increased administrative costs, but no consistent data about improvements to quality of life or clinical outcome measures.

We can conclude a few distinct things about the present circumstances surrounding prior authorization. There is no information to date regarding its cost in terms of nurse practitioner or nursing FTEs, reinforcing the ongoing invisible role of nursing care at all levels, even in the environment of the ACA. It is almost devoid of data regarding metrics that are becoming increasingly important, such as patient satisfaction data with his or her provider, or actual clinical management outcomes. The biggest concern is that process for preauthorization interferes with patient care; if providers are waiting on hold to speak with insurance company pharmacists, they are not seeing patients.

But worse, this process subtly undermines the provider-patient relationship. It can challenge a patient’s faith in his or her provider and treatment plan by creating an impression that we have chosen the wrong medication or did not know the correct medication in the first place. While we wait for a response from an insurance company, patients may interpret this as disinterest, laziness, or negligence. And this may be the greatest unintended consequence of insurance prior authorization; patients who may already be nervous and uncertain about the value of health care are faced with additional delays, near-immediate changes to their plan of care, or even eventual denial of services.

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References