Patient Perspective on Prior Authorization

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Arthritis Foundation®

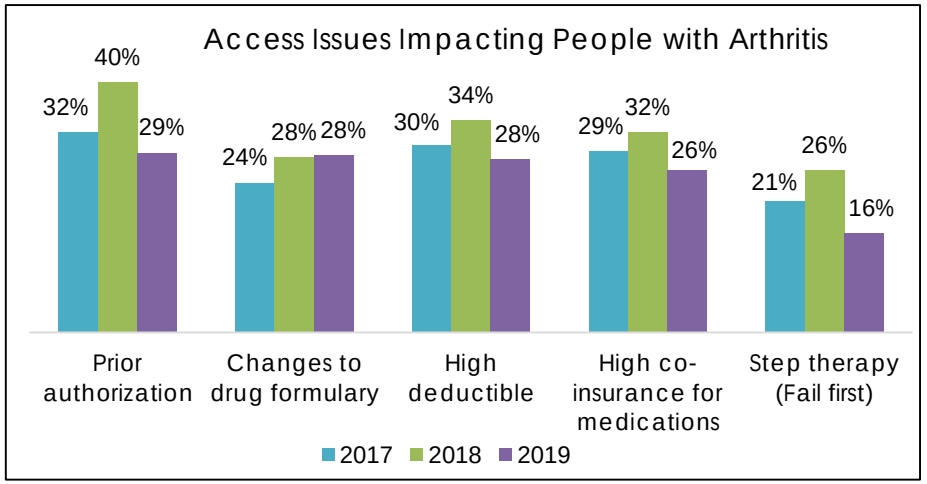
Arthritis Patient Experience with PA

The Issue

- AF survey shows prior auth as the **top health care challenge** every year
- Contributes to overall administrative burden
  - 48% spend more than 5 hours a month managing health coverage, **17% spend more than 15 hours a month**
- Focus groups show across-the-board **frustration at complexity of health system** and constant policy changes without clear communication

The Impact

- Delays in treatment
- Stress and anxiety
- In some cases abandoning therapy
- Administrative-driven decision making



In their own words

"Our daughter was diagnosed with juvenile arthritis. We've had difficulty getting through insurance prior authorizations for changes in biologics and have also had to deal with step therapy. There are definitely things we choose not to do as a family because of the time and costs of medical expenses."

"I have RA and PsA. Every time my body decides that a certain medicine will no longer work, there is a wait for prior authorization and then I usually have to take one day to connect my rheumatologist, the pharmacy, and my insurer to straighten it out."

"My physician decided the biologic medication I was on was not working. It took over six weeks before a new biologic was approved. The pain level required I return to prednisone, which causes other issues, such as weight gain, thinning of bones, interrupted sleep and higher blood glucose levels. I ended up needing a painful procedure to reduce the buildup of fluid in my knee. I can't help but think if I had gotten the new medication approved sooner, I would have been able to avoid this painful procedure."

Our Policy Position on Prior Authorization

The Arthritis Foundation worked with the American Medical Association and other provider groups to establish twenty-one prior authorization principles, including:

•Establish a single, standardized form for physicians to submit prior authorization requests

•Establish electronic systems for the submission of prior authorization requests

•Require prior authorization requests to be completed by insurers within 48 hours of submission or receive automatic approval

•Once approved, permit authorizations to remain in place for up to 12 months for people with chronic conditions, such as rheumatoid arthritis (RA)

•If a prior authorization request is denied, the member must be given clear instructions on how to file an appeal, the information required and deadlines

•Provide a process for expedited appeals, especially for urgent care services

•Health plans should offer providers/practices at least one physician-driven, clinically based alternative to prior authorization, such as but not limited to "gold-card" or "preferred provider" programs or attestation of use of appropriate use criteria, clinical decision support systems or clinical pathways

What Patients Want

- **Streamlined process** with online tracking capability
  - Online portal to file and manage claims; would reduce admin burden for patients and providers
- **Faster response times,** especially for drugs the patient is already taking
- **Transparency** about the process from the beginning all the way through
  - 95% of survey respondents want to know which medications will require prior auth ***before*** its prescribed
  - 75% of survey respondents want transparency every step of the way, not just when approved or denied
  - Patients want relevant contact info and a step-by-step process on how to file an appeal
  - Clear, reasonable explanations for denials