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COMMENTARY

Prior Auth Is a Self-Inflicted Wound; Is There a Way Out?

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A few months ago, a close friend called me in a panic.

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Her mother had been on an oral treatment for relapsed multiple myeloma for nearly 1 year. Originally, she had been prescribed the oral pill pomalidomide as part of her regimen, but it had caused cytopenias, constipation, and nausea even at lower doses. Now, she was tolerating her new pill, ixasomib, quite well.

Then, without so much as a letter from her insurance company, the patient's pharmacy called to tell her that ixasomib was no longer covered without a peer-to-peer conversation given its cost.

The peer-to-peer left the oncology team and patient even more frustrated. After leaving the team on hold for nearly an hour, the insurance company denied the request for ixasomib. The hematologist conducting the peer-to-peer did not seem to understand why the patient had discontinued her previous medication.

Ultimately, the patient was forced to return to the old less expensive drug. Since going back to pomalidomide, she has needed multiple dosing changes to manage the intense drug side effects.

I wish that stories like this were uncommon. I am often reminded of the ongoing challenges related to prior authorization when I see colleagues regaling the Twitterverse with their latest horror stories about an insurance company rejecting standard-of-care treatment or imaging. The data confirm the frequency of these experiences. Among a general cohort of physicians, the American Medical Association has reported that most practices complete 29 prior authorizations per physician every week and spend on average 14.6 hours, or nearly 2 full business days, of staff time each week on these requirements.

Given the growing burden of prior authorization, reform has now become a major policy issue at the federal and state level. Within the past year, organizations like American Society of Clinical Oncology have released policy positions on prior authorization and are devoting sizable advocacy dollars to fight payers' ability to enact it. Entire sections of the ASCO education book are devoted to detailing the negative effects of prior authorization, and recent ASCO-commissioned surveys have highlighted alarming statistics about how prior authorization harms patient care.

As a practicing oncologist, I welcome increased attention to the burdens of prior authorization. This attention shows that our professional organizations care about one of the largest contributors to burnout.

But as a researcher who studies systems of care, I worry that focusing our collective ire on health insurance companies is somewhat misplaced or unlikely to succeed.

Why? Because policy statements, Tweets, and legislation ignore the fact that prior authorization is a self-inflicted wound caused by decades of pharmaceutical companies, health systems, oncologists, and guideline bodies failing to factor costs of care into clinical practice.

Making cost-conscious oncology care a priority would be ideal, but it is also a tall order. That leaves health insurers as the main roadblock to otherwise unconstrained healthcare costs. And prior authorization is what results.

But, as costs continue to rise uncontrollably, the prior-authorization system has ballooned out of control and reining in this system will be quite a challenge. Perhaps, we can look to my oncology practice at a VA Medical Center as a guide.

A Self-Inflicted Wound

In oncology, most medications and imaging are subject to prior authorization, particularly higher cost items, and dealing with prior authorization typically requires an army of staff. As enrollment in commercial health plans or Medicare Advantage skyrockets, prior authorization will only become more prevalent in oncology.

Why is this happening?

The lazy answer to this question is because health insurance companies put profits over patients.

However, prior authorization is a symptom, not a disease. And that symptom is exploding cancer care costs. The causes of high costs are varied: Pharmaceutical companies and device manufacturers set ungodly prices for drugs; oncologists and other specialists are often reimbursed for volume of care, not quality; and hospitals and health systems charge incredible amounts for routine labs and imaging, amounts that are orders of magnitude higher than what these services actually cost.

There is no easy solution to fix the drivers of such costs. One approach to rein in drug costs would be to allow Medicare to negotiate drug prices and set site-neutral pricing could be a promising way to accomplish that.

Another would be to incentivize doctors or health systems to reduce the use of high-cost services. But physicians are often unaware of the costs of a given treatment to a system or patient, and practices reimbursed by volume of care typically have little incentive to curb overall spending.

We are then left with payers, the primary means of reimbursing care and, specifically, utilization management, such as prior authorization and restrictive formularies, as the major mechanism to reduce this spending.

Prior Authorization Is Broken

Here's the rub though: Although payers are incentivized to curb costs through prior authorization, the data that they have to adjudicate therapeutic appropriateness are often terrible.

Administrative claims contain no data on biomarkers or performance status and are notoriously bad at reflecting basic information, such as a patient's stage of cancer. For instance, the positive predictive value of claims-based algorithms to identify stage IV breast cancer is well below 50%, meaning that a claims algorithm that classifies a patient as stage IV is wrong more often than right.

If payers had better data, they could be more selective in their prior-authorization requirements. In other words, if payers could reliably identify who has metastatic breast cancer, an aromatase inhibitor, a common, well-accepted adjuvant therapy in hormone-positive late-stage breast cancer, wouldn't need prior authorization. What we have now is an inefficient system that sets prior authorization as a guardrail for most oncology care and then forces doctors to submit all relevant information about a patient to justify their treatment choices.

Keeping up with oncology treatment advances is also a challenge and requires tremendous expertise. Many insurers delegate their prior-authorization responsibilities to medication management companies, such as Magellan Rx or New Century Health, who maintain proprietary treatment pathways.

These companies anchor their prior-authorization requirements to common guidelines. That would be fine if guideline-producing bodies like the National Comprehensive Cancer Network (NCCN) provided more firm recommendations on high-value treatments.

The NCCN recommendations, however, are expert-driven more than evidence- or value-driven. Often, therapies with less evidence make it into recommended treatment guidelines, and in some cases, the NCCN will equally recommend five options for treating a certain cancer, even when there is an obvious lower-cost option.

The effect of this, however, is that payers may then cover these five options, despite a 40-fold price difference among them, but then lean on requiring prior authorization for everything rather than being selective. Broad rather than targeted use of prior authorization alongside well-known issue like uncertain timelines, huge numbers of forms, and nonexperts doing peer-to-peers make for a huge mess.

What Can We Do?

How can we begin to solve the prior-authorization crisis? A first step would be for guideline bodies to have more teeth in their recommendations. If NCCN and other guideline bodies, for instance, incorporated cost into their recommendations and designated these as "preferred" regimens, then clinicians could have better direction on therapy selection and payers could align their prior-authorization policies with those recommendations. If patients had adverse effects with low-cost drugs, then

a preferred alternative could be specified in such guidelines rather than subject patients, like my friend's mother, to a toxic drug.

Second, payers could tailor the intensity of prior-authorization requirements to the type of physician and clinical scenario at hand. Payers have rich data on practice patterns of oncologists. Payers should incentivize oncologists who follow guideline-based, high-value treatment pathways by lowering the need for frequent peer-to-peers or other prior authorization for "good performers." This strategy, often termed gold carding, would use relief from prior authorization as a carrot.

Similarly, payers could reward practices that implement clinical pathways that enforce high-value care. For example, a practice could develop a treatment pathway that emphasizes access to urgent care to avoid hospitalizations as well as prioritizes access to relatively lower cost but equally effective options for therapy. If a payer reviewed and approved the pathway, perhaps payers could propose relief of future prior authorizations for practices whose oncologist practice on this pathway.

Third, payers could step up the intensity of prior authorization for certain high-cost or low-value treatments and lessen requirements for more routine services. For example, if every initial staging PET-CT required a peer-to-peer, oncologists would spend most of the day on the phone. Rather, lower-level tasks such as imaging may require a simple electronic EHR message, whereas high-cost items such as indefinite systemic therapy may require more frequent peer-to-peers.

Fourth, health systems and real-world–data companies should devise better data sharing partnerships with payers so that payers could automatically examine attributes that clarify the choice of therapy. For example, if a payer could view that a patient had estrogen receptor/progesterone receptor–positive early-stage breast cancer post-surgery, perhaps that payer would not require a prior authorization for an aromatase inhibitor. These real-time data sharing partnerships could reduce friction points in the system.

Finally, researchers and other groups should partner with payers to continually examine the effectiveness of any prior-authorization program. If a prior-authorization policy is no longer effective because evidence changes and evolves, then payers should consider retiring it.

In my primary oncology practice at a VA Medical Center, none of my treatments require an external prior authorization. Why? Because our local practice agreed to an established formulary, and national treatment pathways firmly specify a recommended treatment course.

Do I sometimes go off-pathway? Yes, when I feel there's a compelling reason. But that requires a structured electronic form to a central pharmacy body. I get a response within 24 hours, with no onerous prior-authorization form or lengthy peer-to-peer.

Though there are plenty of unique qualities about the VA, the fact is that health systems and guideline bodies assuming the burden of cost containment could reduce prior-authorization requirements from payers.

Ultimately, the goal should be for oncologists to choose the highest-value treatment possible. Perhaps then, when the end-goal of cost-conscious oncology care with payers maintain an arm's length from the patient-doctor relationship, we could all stop shouting at the wind about the burden of prior authorization.

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