Consumers' Perspective: Prior Authorization & Prescription Drugs

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1. National Data on Prior Authorization for Prescription Drugs

Carl Schmid, HIV+Hepatitis Policy Institute

National Data on Brand Name First Fills

- **Exchange Plans (2018-2024 averages)**
  - 51% were paid (down to 41% in ‘24)
  - 24% rejected (formulary exclusion)
  - **25% rejected (utilization management)**
    - **Increased from 17% in ‘18 to 31% ‘24**

- **Commercial Plans**
  - 64% were paid
  - 15% rejected (formulary exclusion)
  - **22% rejected (utilization management)**

Formulary-Related Insurance Denials of Single-Source Branded Drugs in the United States, JAMA, Published Online: July 9, 2026 2026;336;(8):664-672. doi:10.1001/jama.2026.8702

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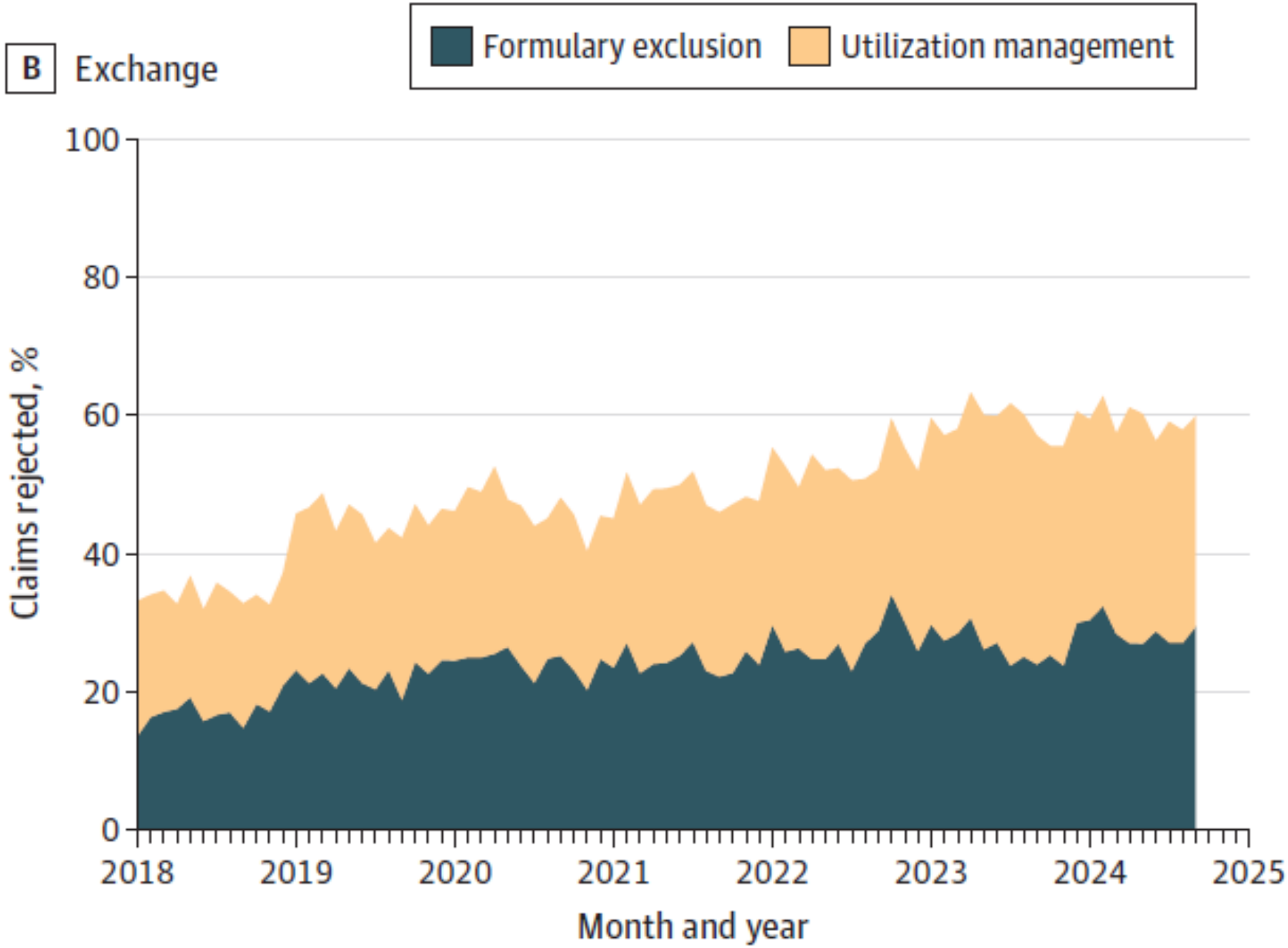

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Fill Behavior Following Rejection
(within 90 days)

- **Exchange Plans (2024)**
  - 41% were paid first fill
  - 21% eventually filled
  - 6% filled w/ a substitute
  - **34% never filled**
    - **Increase from 16% in ‘18**

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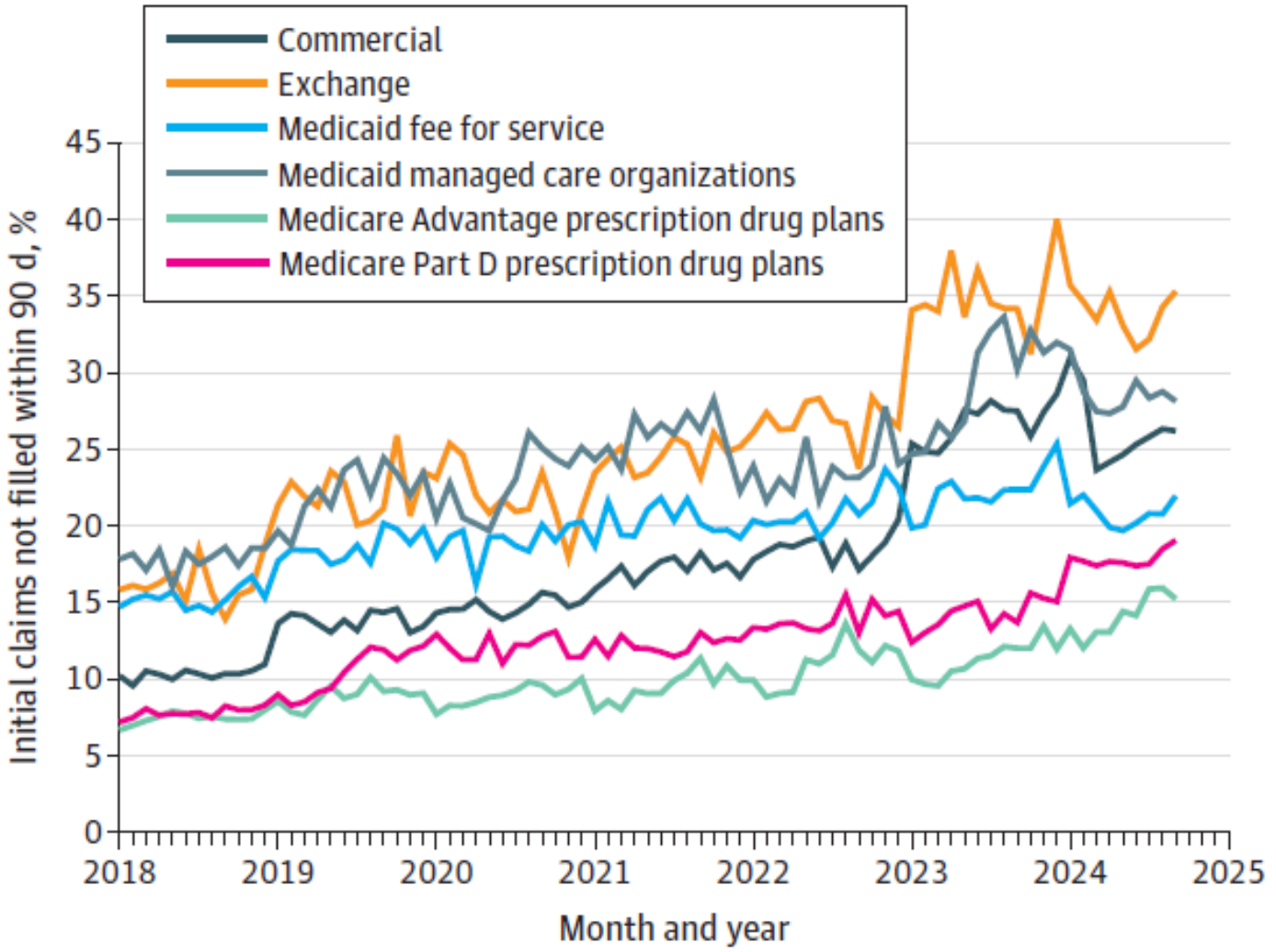
Figure 3. Line Graph of Monthly Share of Initial Attempts With No Molecule or Therapeutic Substitute Fill Within 90 Days, by Payer



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2. Research Overview: PA Decisions Not Always Grounded in Evidence-Based Standards

Amy Killelea, Equality Arlington (and researcher with Georgetown's Center on Health Insurance Reforms and UVA's Division of Infectious Diseases and International Health)

Imposition of Prior Authorization Varies Considerably

Example: Pre-exposure prophylaxis (PrEP) for HIV prevention

JAMA Network™

Table 3. Regional Prior Authorization Requirements of F/TDF and F/TAF Among Qualified Health Plans, 2018-2020[a]

	Qualified Health Plans, No./Total No. (%)			
Prior authorization by year	Northeast	Midwest	South	West
Both F/TDF and F/TAF				
2018	0	236/4332 (5.4)	2307/8023 (28.8)	30/3230 (1.0)
2019	64/2851 (2.2)	81/3824 (2.1)	1534/5991 (25.6)	32/3350 (1.0)
2020	0	79/5147 (1.5)	1538/7401 (20.8)	30/4021 (1.0)
Only F/TDF				
2018	20/2574 (0.8)	535/4332 (12.3)	806/8023 (10.0)	220/3230 (7.6)
2019	8/2851 (0.3)	481/3824 (12.6)	850/5991 (14.2)	182/3350 (5.9)
2020	232/2872 (8.1)	2036/5147 (39.6)	3466/7401 (46.8)	289/4021 (8.8)
Only F/TAF				
2018	0	27/4332 (0.6)	0	0
2019	0	0	0	0
2020	0	5/5147 (0.1)	0	5/4021 (0.2)
Neither				
2018	2554/2574 (99.2)	3534/4332 (81.6)	4910/8023 (61.2)	2635/3230 (91.3)
2019	2779/2851 (97.5)	3262/3824 (85.3)	3607/5991 (60.2)	2877/3350 (93.1)
2020	2640/2872 (91.9)	3027/5147 (58.8)	2397/7401 (32.4)	2948/4021 (90.1)

Abbreviations: F/TAF, emtricitabine/tenofovir alafenamide; F/TDF, emtricitabine/tenofovir disoproxil fumarate.

[a] Prior authorization assessed for plans that covered both F/TDF and F/TAF.

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McManus KA, Fuller B, Killelea A, Strumpf A, Powers SD, Rogawski McQuade ET. Geographic Variation in Qualified Health Plan Coverage and Prior Authorization Requirements for HIV Preexposure Prophylaxis. JAMA Netw Open. 2023 Nov 1;6(11):e2342781. doi: 10.1001/jamanetworkopen.2023.42781. PMID: 37948076

Variability Extends to Prior Authorization Clinical Criteria

Example: Continuous glucose monitors (CGMs) for diabetes

DEMONSTRATED DIFFICULTY ACHIEVING GLYCEMIC TARGETS	CARRIERS		
Difficulty achieving glycemic targets required for any CGM approval (not aligned with the 2025 ADA Standards of Care)	National Carrier A	Regional Carrier A	
Difficulty achieving glycemic targets required only if patient is not on insulin (not aligned with the 2025 ADA Standards of Care)	National Carrier B National Carrier C	Regional Carrier C	State Carrier A State Carrier B
Difficulty achieving glycemic targets required for implantable device (not aligned with the 2025 ADA Standards of Care)	National Carrier C	Regional Carrier C	State Carrier A State Carrier B
No difficulty achieving glycemic targets required (aligned with the 2025 ADA Standards of Care)		Regional Carrier B	State Carrier C* State Carrier D
Unknown	National Carrier C**		

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Georgetown University McCourt School of Public Policy Center on Health Insurance Reforms, Variability in Continuous Glucose Monitor Coverage in the Fully Insured Market (December 2025).

Variability + Opacity = Arbitrary Decision Making

- The clinical criteria insurers use to guide decision on prior authorization are often buried, incomplete, or unavailable to the consumer
  - There is also sometimes variation in clinical criteria within the same carrier for the same medication or device based on whether it is covered as a pharmacy benefit or a medical benefit
  - Many insurers contract with third-party vendors, like Interqual or MCG, whose clinical coverage criteria are proprietary
- In the drug and device space, PA is often cited as way to drive consumers to the safest, most effective, and most cost-effective option
  - BUT increasingly complex PBM dynamics mean that PA may actually be applied to options with lower net prices, but higher rebates
- PA should be looked at in tandem with step therapy; many insurers are moving away from an explicit step therapy UM designation, but may be using PA to the same effect
  - E.g., Georgetown's diabetes device research found that insurers rarely applied step therapy, but the PA criteria did require use of certain device types before allowing access to a non-preferred option

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3. xxxxx

Deborah Steinberg, The Kennedy Forum

Clinical criteria for PA and other UM

State regulators can require insurers to:

- Use evidence-based clinical criteria that reflect up-to-date, generally-accepted standards of care
- Ensure that plans and AI tools properly apply criteria
- Require insurers contracting with third parties provide access to PA criteria
  - NAIC FAQ – “if the proprietary information was used in the business of insurance by the insurer, then it would have been subject to [state] regulatory authority”
- Make criteria available to enrollees, potential enrollees, and providers

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Providing consumers with the information they need on PA denials

- Individualized written notice that explains the reason for the adverse benefit determination, including clinical basis and criteria used
- Any additional information required (e.g., medical records, diagnostic tests)
- Explanation of appeal rights and processes, including grievances, independent medical review, and expedited consideration
- Notices should be consumer-tested and in plain language

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Is prior authorization appropriate?

- Require insurers to periodically:
  - review services subject to PA/UM
  - clinical criteria used
  - remove services from PA/UM (See, e.g., CA SB-306)
- Monitor exempting select providers from PA (aka “gold carding”) for potential harm (e.g., adverse selection)
- Pre-launch and ongoing testing of AI tools used for PA
- Meaningful human in the loop (see Pro Publica: Doctor at Cigna Said Her Bosses Pressured Her to Review Patients’ Cases Too Quickly. Cigna Threatened to Fire Her

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States/NAIC are in the best position to protect consumers from PA harms

- Federal interoperability standards helpful but CMS monitoring and compliance lacking
  - ➔ Example: CMS PA metrics reporting template issued five months after March 31, 2026 effective date
- No standardized way for consumers to access PA information at time of plan selection
  - See Look Up Your Health Plan's Denial Rate: Report Card | AuthDenied
- State compliance monitoring
  - Plan certification process
  - Market conduct exams/data calls

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Ensure that Consumers Can Easily Access Prior Auth Information

- Ensure that information for all services is published in one place
  - Currently prior auth criteria are often split across different websites/documents for different services (e.g. prescription drugs vs medical services vs behavioral health services)
  - Services for different market segments may be published in different documents
- Publish prior auth information, including clinical criteria, in consumer-friendly search tools (see e.g. Nebraska LB77)
  - Ensure that search tools accept consumer-friendly search terms
  - Avoid login requirements, as these block caregivers and potential plan enrollees from accessing
  - Allow consumers to easily find rules that apply to their own health plan
- Ensure that information in published documents is the consistent with the rules as applied in internal prior auth systems, process, and other regulated documents.

https://www.osi.state.nm.us/wp-content/uploads/2026/08/NM-Prior-Auth-Assessment-Summary-of-Findings-FINAL.pdf

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Thank you!

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See more of our work:

https://consumeradvocacyforhealth.org/

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