eHI Explains

Prior Authorization

What is Prior Authorization?

Prior Authorization (PA) is a decision by a health insurer or plan that a healthcare service, treatment plan, prescription drug, or durable medical equipment is medically necessary.

What is the PA Process?

1. A physician decides the procedures, treatment, and medication a patient needs for their care.

2. The physician or staff fills out paperwork and online forms requesting the patient's eligibility from payers (insurers).

3. Based on clinical guidelines and the patient's insurance coverage levels, payers will decide if the treatment, drug, or equipment is:
   - **Authorized.** It has been accepted as a covered medical expense and the insurance company will cover the cost.
   - **Denied.** It is not considered a covered medical expense and the insurance company will not cover the cost. Patients can appeal the decision.

4. Pharmacy Benefit Managers (PBMs) will check the guidelines for prescription medication and will make the same decisions as the insurance company.

5. The patient's provider will inform them how to receive their treatment and medications from the pharmacy and other providers.

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eHealth Initiative's Prior Authorization Project

With the burdens of prior authorization felt by everyone in healthcare, including patients, payers, vendors and providers, eHI brought together executives from each stakeholder group to establish a set of considerations to help improve the current prior authorization environment and to respond to the widespread challenges and dissatisfaction healthcare professionals have with prior authorization. Stakeholders agreed upon a series of key points:

1. Transparency of payer policy and evidence-based clinical guidelines available at the point of care may, in many cases, reduce the need for prior authorization and minimize care delays.

2. Reducing the overall volume of services and drugs requiring prior authorization could decrease administrative burdens and costs for all stakeholders. As long as care continues to be consistent with evidence and the person's insurance coverage, prior authorization may not be needed (or needed as frequently) for certain conditions, people, or situations.

3. Payers, healthcare professionals and vendors should use existing, industry-endorsed standards whenever possible and explore incorporating new electronic standards that have the capability to improve the prior authorization process.

4. Payers and healthcare professionals should explore alternative payment models that promote bundled authorization for procedures, medications, and durable medical equipment that are associated with a particular episode of care.

Prior authorization is not just another difficult policy issue or back office function. It is an important aspect of patient care that significantly impacts health outcomes.

About eHealth Initiative

eHealth Initiative and Foundation (eHI) convenes executives from every stakeholder group in healthcare to discuss, identify, and share best practices that transform the delivery of healthcare, through technology and innovation. eHI, and its coalition of members, focus on education, research, and advocacy to promote the use of sharing data to improve healthcare. Our vision is to harmonize new technology and care models in a way that improves population health, consumer experiences and lowers costs. eHI serves as a clearinghouse and has become the go-to resource for industry through its eHealth Resource Center. For more information, visit www.ehidc.org/priorauth. To join the conversation on Prior Authorization, follow eHI's Prior Authorization showcase page and connect with us on LinkedIn, Facebook, and Twitter.