

UTILIZATION MISMANAGEMENT:

Assessing Compliance with Step Therapy and
Prior Authorization Laws in Select States



January 2020

Survey Findings from New York

 **AIMED ALLIANCE**

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I. Introduction

Over the past two years, New York lawmakers have enacted laws to protect health care consumers against unreasonable step therapy and prior authorization policies. This report presents the findings of a survey commissioned by Aimed Alliance to assess compliance with these new laws by health plans and the degree to which the laws are being enforced by state regulatory agencies.

A. Overview of Step Therapy

Step therapy policies require insured individuals to try and fail on alternative treatments specified by a health plan, sometimes with adverse effects, before the health plan will cover the prescribed treatment.¹ Due to rising health care costs, health plans often use step therapy as a cost-containment technique. When step therapy is used appropriately, it can steer patients towards less risky and lower cost treatments as first-line treatment options.² However, some step therapy policies are inconsistent with sound scientific and clinical evidence, require patients to try and fail on the same treatment multiple times, and do not have adequate exceptions processes in which a practitioner can submit a request to the health plan to override the step therapy protocol.³ In such instances, step therapy can interfere with the practitioner-patient relationship, cause care delays that interrupt disease stability, and result in disease progression and relapse, thereby increasing health care utilization.⁴

New York's step therapy law went into effect in January 2017.⁵ This law requires health plans to grant a step therapy exception if the health plan's required treatment is likely to cause a patient harm, be ineffective, or if the patient has already tried and failed on the required medication.⁶ The health plan must grant the exception request within 24 hours during emergency situations and within 72 hours in non-emergency situations.⁷ If the plan fails to provide a response within the given timeframe, the request is automatically deemed approved.⁸ New York's step therapy law applies to health maintenance organizations, exchange plans, municipal cooperative health benefit plans, Medicaid managed care plans, and Child Health Plus.⁹

B. Overview of Prior Authorization

Prior authorization policies require a health care provider or an insured individual to obtain approval from the health plan before the plan will cover the cost of a health care product or service.¹⁰ Prior authorization is often used by health plans as a cost-containment measure intended to prevent health care professionals from prescribing high-cost treatments and services that are not medically necessary.¹¹ However, prior authorization standards can be inconsistent with medical standards of care.¹² Additionally, health plans sometimes use outmoded methods of communication when accepting requests for prior authorization, such as fax or mail, which can be unreliable. Plans may also take several days, or even weeks, before responding to a prior authorization request.¹³ When prior authorization is used inappropriately, it can cause care delays that prevent patients from accessing medically necessary treatments and services when they are needed.¹⁴ These care delays can cause disease progression and relapse that can result in increased health care utilization.¹⁵

New York's prior authorization law went into effect in August 2018.¹⁶ Under the law, health plans may not impose prior authorization requirements in emergency situations and are required to respond to prior authorization requests for non-emergency situations within three business days.¹⁷ If the plan fails to provide a response within the given timeframe, the request is automatically deemed approved for Medicaid plans or an adverse determination subject to appeal for other plans.¹⁸ Prior authorization may not be required more frequently than necessary.¹⁹ Health plans may accept prior authorization requests electronically.²⁰ New York's prior authorization law applies to health maintenance organization plans, exchange plans, municipal cooperative health benefit plans, Medicaid managed care plans, and Child Health Plus.²¹

C. Scope of the Survey and This Report

While these laws have advanced strong protections for consumers, those protections are ineffective if health plans are not complying with the laws. Aimed Alliance commissioned a survey of health care providers practicing in the state to understand whether the step therapy exception and prior authorization request processes have become easier since enactment of the laws. The information was used to assess whether health plans are complying with step therapy and prior authorization requirements following the laws' enactment and whether state regulatory agencies are taking steps to enforce the laws against noncompliant health plans.

II. Methodology

Aimed Alliance commissioned a global public affairs firm, InVeritas, to conduct a digital survey of health care professionals in New York. The survey was distributed to health care professionals through email, and 213 individuals completed the survey fully. Internal screening questions included whether recipients were familiar with the process for filing insurance claims and whether they accept various types of insurance. Of the health care professionals who completed the survey, 16 percent were physicians and 68 percent were nurses. The remaining 16 percent were other types of health care professionals, including physician assistants, medical technicians, and managers and administrators of medical offices. The vast majority of the survey respondents (87 percent) have five or more years of experience in the medical profession. The survey examined health care professionals' experiences with step therapy and prior authorization policies following the recent enactment of laws that govern the use of these policies.

Based on the findings of the survey, Aimed Alliance identified several shortcomings in the compliance and enforcement of step therapy and prior authorization laws.

III. Findings from the Survey

A. Step Therapy

Nearly half of respondents believe that the recent changes have improved patients' ability to access their medications.

Almost half of respondents (45 percent) agree that recent legal changes governing step therapy have improved patients' ability to access medications.



Respondents are divided over whether recent changes in the law have improved the process for requesting a step therapy exception. Many respondents feel that the amount of time spent on administrative tasks and paperwork has increased.

About one-third of respondents (32 percent) agree that the step therapy exception process has gotten easier since the law has passed. Nearly half of respondents (45 percent) do not believe that administrative tasks related to obtaining a step therapy exception take less time since the law was enacted, and only 32 percent of respondents felt that the administrative paperwork takes less time.

Most professionals believe that recent changes in the law have not improved the likelihood of obtaining a step therapy exception.

New York's step therapy law requires health plans to grant a step therapy exception if the health plan's required treatment is likely to cause a patient harm, be ineffective, or if the patient has already tried and failed on the required medication before.

Nearly half of survey respondents (46 percent) believe that the changes in the law have not led to any significant difference in whether insurers approve exception requests. Of respondents, 21 percent believe that insurers are less likely to approve the requests, while 33 percent believe that insurers are more likely to approve the requests.

Health plans are meeting step therapy exception request deadlines most of the time, and recent changes in the law have made denials slightly less frequent.

New York's step therapy law requires health plans to act on an exception request within 24 hours in emergency situations and within 72 hours in non-emergency situations. If the plan fails to provide a response within the given timeframe, the plan is required to automatically deem the request approved. Most survey respondents (58 percent) indicated that insurers have been responding to requests within the legally required time limits "every time" or "most times," while 41 percent say that insurers are meeting the deadlines "occasionally" or "almost never."

More than half of surveyed health care professionals (51 percent) do not believe the law has made a significant difference in the frequency of denials for step therapy exceptions. Additionally, 23 percent of survey respondents believe that denials are more frequent.

Even though recent changes in the law prohibit this, health plans often require patients to try and fail on the same treatment multiple times as part of a step therapy protocol.

New York's step therapy law requires health plans to grant a step therapy exception if the patient has already tried and failed on the required medication before. Despite this requirement, almost half of respondents (44 percent) indicated that patients are required to try and fail on the same medication more than once "every time" or "most times," while 55 percent of respondents say this occurs "occasionally" or "almost never."

B. Prior Authorization

Recent changes in prior authorization law have had a modest impact on patients' ability to access medications, but many feel that the process for obtaining a prior authorization approval has become more difficult.

Just under half (42 percent) of survey respondents agree that recent changes in the law have improved patients' ability to access medications, while 32 percent of respondents disagree.

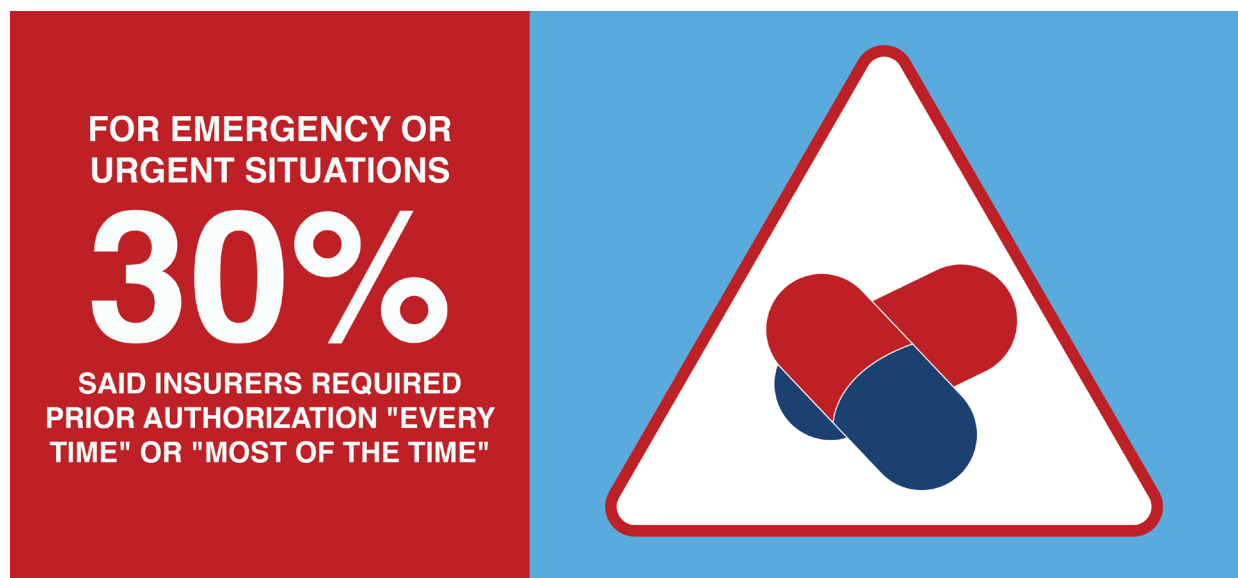
More often than not, respondents feel that recent changes in the law have not improved the prior authorization approval process and that the amount of time spent on administrative tasks and paperwork has increased.



Many New York health care professionals feel that recent changes in the law have not provided relief from burdensome administrative requirements. For example, only 33 percent of survey respondents believe that that prior authorization paperwork has been simplified. Additionally, only 37 percent of survey respondents believe that the process for submitting a request for prior authorization approval is now easier. Only one-third of survey respondents feel that administrative tasks related to obtaining a prior authorization approval take less time, and 31 percent believe that completing administrative paperwork related to obtaining a prior authorization approval takes less time.

Even though recent changes in the law prohibit this, health plans are requiring prior authorization in emergency situations.

New York law prohibits health plans from requiring prior authorization in emergency situations. Yet, 30 percent of respondents said insurers have required prior authorization “every time” or “most of the time” for emergency or urgent situations. They also reported that prior authorization is required “every time” or “most of the time” in 39 percent of non-emergency situations.



Health plans are not consistently meeting the deadlines for acting on prior authorization requests.

New York law requires health plans to respond to prior authorization requests for non-emergency services or treatments within three business days. Despite this, only nine percent of survey respondents indicated that health plans are acting on prior authorization requests within three business days “every time.” About one-third of survey respondents (30 percent) indicated that health plans are acting on prior authorization requests within three business days “most times,” and 44 percent of survey respondents indicated that health plans “occasionally” act on prior authorization requests within three business days.

Frequency of prior authorization denials has fallen slightly.

Forty-three percent of respondents do not believe that the frequency of prior authorization request denials has changed. However, 37 percent claim that denials have been less frequent.

C. Appeals and Complaints

While a majority of survey respondents appeal coverage denials, a significant portion of them simply write a prescription for a different medication.

When a prior authorization request or a request for a step therapy exception is denied, 58 percent of survey respondents indicate that they appeal the denial, while 37 percent of survey respondents choose to write a prescription for a different medication.

Of those who appeal coverage denials, most are at least somewhat successful.

When denials are appealed, 49 percent of survey respondents indicate that their appeals are “sometimes” successful, while 29 percent of survey respondents indicate that their appeals are successful “most times.”

The vast majority of survey respondents do not seek enforcement from the state when insurers deny an appeal.

Only 11 percent of respondents say they have filed complaints with the state’s insurance commissioner (i.e., New York Superintendent of Financial Services) or attorney general when appeals are denied, while 89 percent have not.

Health care professionals believe that the state is generally not doing enough to enforce the law.

A majority of survey respondents (54 percent) think the state is “doing some things but could be doing more” to enforce step therapy and prior authorization laws, while 29 percent of survey respondents believe that the state is “not doing nearly enough to enforce the law.”

IV. Conclusion

In passing step therapy and prior authorization laws, New York lawmakers added important protections for health care consumers intended to ensure timely access to appropriate treatments. Our report found that, while some practitioners believe that these laws have reduced administrative waste and improved access to care, there is still room for improvement. Additionally, our report identified several areas in which plans may not be complying with the laws.

In efforts to ensure that health plans are complying with New York's step therapy and prior authorization laws, practitioners should help their patients by seeking exceptions, going through the appeals process, and filing complaints when health plans' actions are inconsistent with the law. Additionally, patient advocacy groups can empower patients to speak up and ask their practitioners for assistance to get access to medically necessary treatments if their practitioners are reluctant to go through the exception or appeals processes. Patients can also be encouraged to file complaints if plans deny access to care in violation of state law. In taking these steps, health care stakeholders can improve patient access to medically necessary care and reduce barriers that can negatively impact patient health.

V. About Aimerd Alliance

Aimerd Alliance is a 501(c)(3) non-profit health policy organization that seeks to protect and enhance the rights of health care consumers and providers. To advance its mission, Aimerd Alliance conducts legal research and analysis; develops sound, patient-centered recommendations; and disseminates its findings to inform policy makers and increase public awareness. To learn more about Aimerd Alliance, go to www.aimerdalliance.org.

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VI. Endnote

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