The burden of obtaining prior authorizations for medications has been steadily increasing for physicians and their support staff. Health carriers are requiring pre-authorization for drugs ranging from generic acne medications to biologics. Some dermatologists’ offices have even hired a full-time employee to process prior authorizations. The American Academy of Dermatology Association (AADA) has been tracking state legislation that may alleviate these burdens and improve access to necessary medications for patients.

**Enacted legislation**
The governor of Ohio signed legislation requiring prior-authorization requirements to be listed on health insurers’ websites. The new law, effective Sept. 13, also allows providers and patients to obtain prior authorizations through a web-based system, and guarantees an expedient turnaround on prior-authorization requests as well as a streamlined process for appealing denied requests. A new law in New Hampshire requires health insurers, health maintenance organizations, health services corporations, medical services corporations, and preferred provider programs to use and accept only the uniform prior-authorization forms and criteria developed by the state Insurance Commissioner. The new law took effect in June.

**Pending legislation**
Legislation in New York would require the Commissioner of Health and the Superintendent of Financial Services to develop standards for prior-authorization requirements. The bill stipulates that the departments shall take into consideration existing electronic prior-authorization standards including those set by the National Council for Prescription Drug Programs electronic prior authorization standard transactions. The bill awaits the governor’s signature.

The AADA and the Dermatological Society of New Jersey supported legislation which would require the Commissioner of Banking and Insurance to develop a standard prior-authorization request form to be utilized by all network providers. The bill passed out of the Assembly Financial Institutions and Insurance Committee on June 2.

Although legislation in Pennsylvania does not address the prior-authorization process for prescription drugs, a bill has been introduced that would reform prior-authorization processes for medical tests and procedures. The bill would require the Department of Insurance to develop a standard form. Additionally, the legislation would require preauthorization restrictions and adverse determinations to be based on written clinical criteria, and would require insurers to make and communicate the determination no later than two days after receiving the necessary information. The bill has been referred to the House Health Committee.

**Dead legislation**
Legislation in West Virginia would have set forth provisions requiring health plans to accept universal prior-authorization forms (to be developed by the state’s Insurance Commissioner). The authorization would be valid for one year. The bill would require prior-authorization for
chronic disease management drug benefits only when a patient is not medically stable on the prescribed drug or has not completed prior step-therapy restrictions, if required, for the prescribed drug. Session adjourned in early March, and the bill did not move beyond committee referral.

A bill in Minnesota would have taken multiple steps to improve the prior-authorization process. The bill would have increased transparency by requiring plans to inform consumers before open enrollment which drugs are covered and how the cost will be shared. The bill also would have required: prior-authorization approval to last the entire enrollment year, limited formulary and medication covers changes during the enrollment year, and a transition process for patients changing plans to prevent gaps in prescription drug coverage. The plans would have provided coverage for 60 days while the patient transitions. The bill would also have required health plans to establish a medical exceptions process that allows enrollees and providers to request and obtain coverage approval. The Minnesota Dermatological Society is a member of the “Fix PA Now” Coalition, supporting the bill along with 45 other patient and provider organizations. The legislature adjourned without moving the bill beyond referral.  

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Would require pre-authorization restrictions to be based on written clinical criteria, and insurers to communicate pre-authorization decision no later than two days after receiving required information.

Would require the Commissioner of Health and the Superintendent of Financial Services to develop standards for prior-authorization requirements.

Requires insurers to only use pre-authorization forms and criteria provided by the Insurance Commissioner.

Would require the Commissioner of Banking and Insurance to develop a standard prior-authorization request form to be utilized by all network providers.

Allows providers to obtain pre-authorizations through a web-based system to expedite the request, and offers a streamlined appeals process.