

Consumers' Perspective: Prior Authorization & Prescription Drugs

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October 5, 2026

1. National Data on Prior Authorization for Prescription Drugs

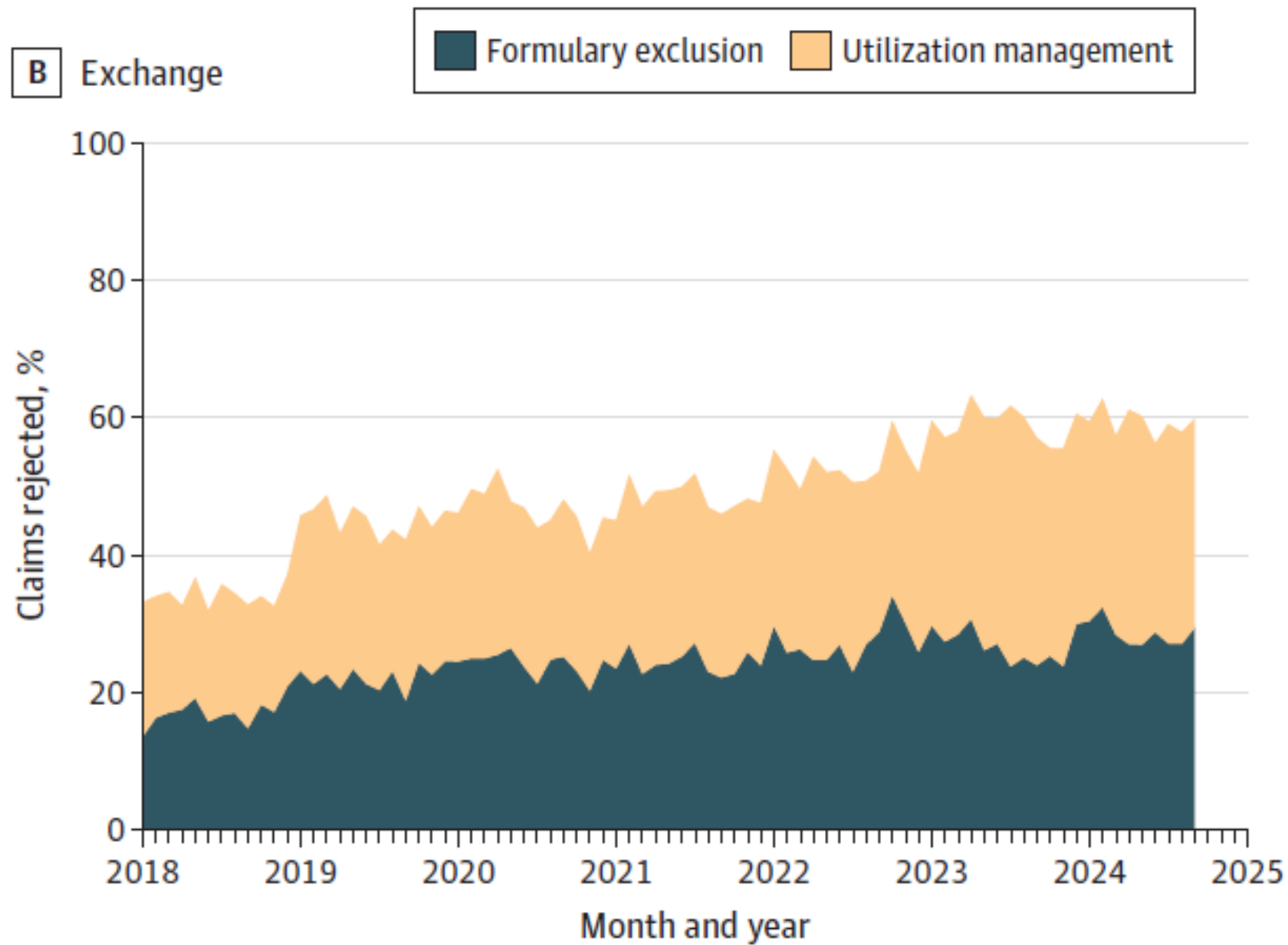
Carl Schmid, HIV+Hepatitis Policy Institute

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

B Exchange

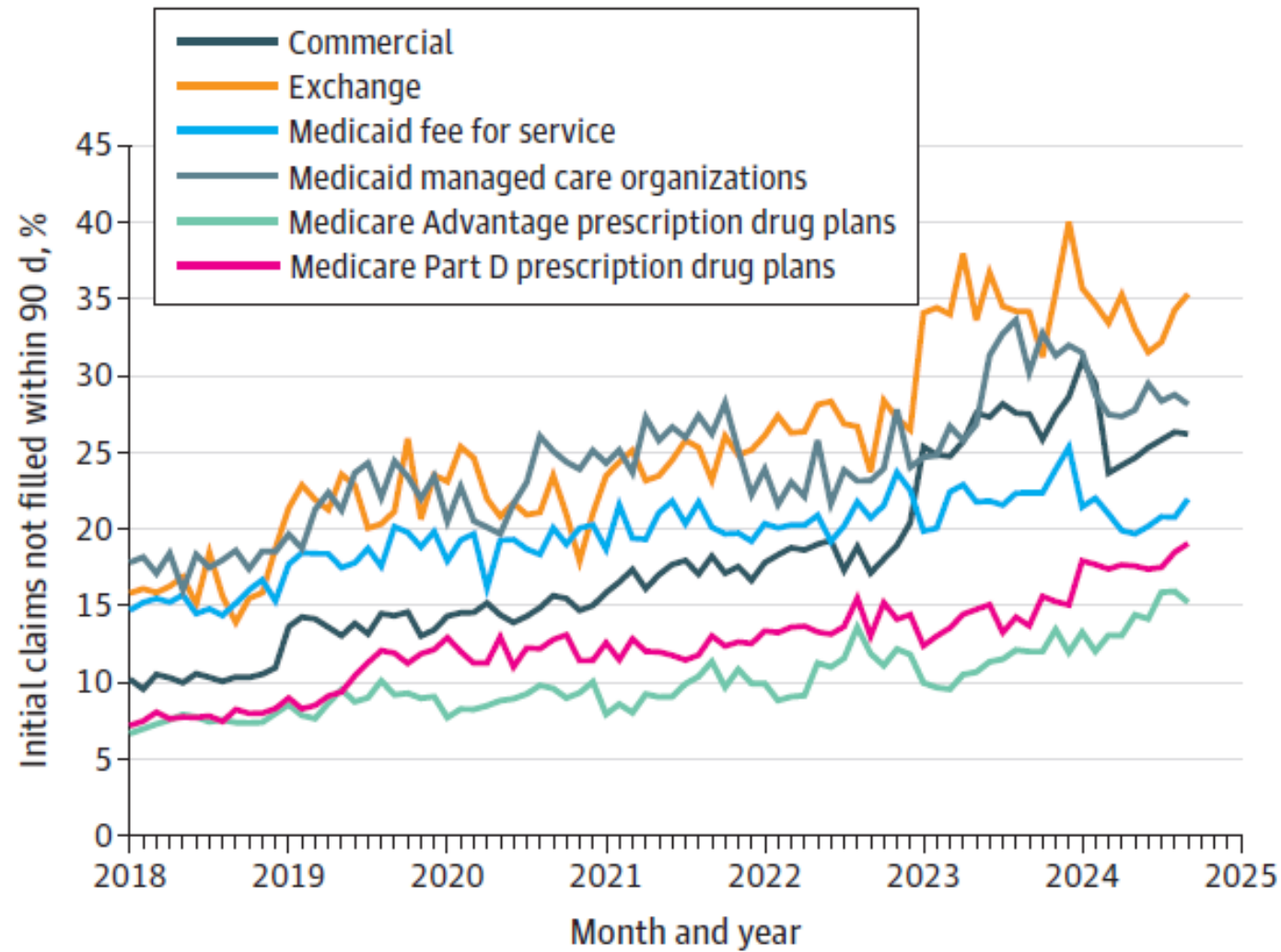


Fill Behavior Following Rejection

(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**

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



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

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

Prior authorization by year	Qualified Health Plans, No./Total No. (%)			
	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**		

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

3. Example: Substance Use Disorders and Mental Health

Deborah Steinberg, The Kennedy Forum

Unnecessary Prior Authorization Requirements on SUD & MH Medications

- Delayed access to needed medications
 - Can lead to patients no longer able or willing to seek treatment
- Decreased clinical effectiveness
- Increased adverse health outcomes and costlier service utilization
 - Hospitalizations and emergency department visits
 - Other health conditions exacerbated by untreated SUD & MH
- Avoidable harms across different areas of life
 - Criminal-legal system involvement
 - Less engagement in work, education, and the community

[https://www.amjmed.com/article/S0002-9343\(25\)00553-4/pdf](https://www.amjmed.com/article/S0002-9343(25)00553-4/pdf)

Benefits to Removing Prior Authorization on SUD & MH Medications

- Increased access to needed medications
 - Especially when the window in which patients are willing and able to access treatment is short
- Better treatment initiation and retention
- Better health outcomes, including lower likelihood of recurrence and risky substance use
- Decrease in emergency department utilization and hospital admissions
 - Reduces overall costs

[https://www.amjmed.com/article/S0002-9343\(25\)00553-4/pdf](https://www.amjmed.com/article/S0002-9343(25)00553-4/pdf)

Considerations

- Not just the prior authorization on the medications themselves, but also:
 - Dosage or quantity limits
 - Step therapy or “fail first” policies
 - Coverage criteria and alignment with the medical field
- Some medications (methadone) may be part of a “medical” benefit, or available over-the-counter
- Compliance with the Mental Health Parity and Addiction Equity Act, both as written and in operation

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Thank you!

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