

## POLICY BRIEF

### KEY TERMS

**Gold Carding** – The practice where payers waive prior authorization on services and prescription drugs ordered by providers with a proven track record of prior authorization approvals.

**Payers** – Health insurance plans that negotiate or set rates for provider services, collect revenue through premium payments or tax dollars, process provider claims for service, and pay provider claims using collected premium or tax revenues.

**Pharmacy Benefit Managers** – Third party administrators of prescription drug programs used by a variety of sponsors including commercial health plans, self-insured employer plans, Medicare Part D plans, the Federal Employees Health Benefits Program, and others.

**Prior Authorization** – A paper-based or electronic process by which payers require providers and/or patients to obtain approval for a prescribed procedure, service, or medication in advance of its delivery or administration.

### Background

In response to the rising costs of health care and prescription drugs; policymakers, providers, and payers are seeking strategies for achieving cost-effective use of resources. One such approach from payers and pharmacy benefit managers (PBMs) is the use of prior authorization. Prior authorization is a paper-based or electronic process by which payers require providers and/or patients to obtain approval for a prescribed procedure, service, or medication in advance of its delivery.<sup>1</sup> While prior authorization is being conducted, patients are left waiting to receive care that their clinician has determined they need. These waits can be significant, leading to increased suffering and elevated risk for a negative health outcome—including death. Despite significant concerns from physicians across the medical community, the burden and negative impacts of prior authorization continue to grow while providing unclear benefits to quality of care or to the health care system overall.<sup>2</sup>

Many states have proposed or implemented legislation to limit the burden that prior authorization has placed on physicians and other health care providers.<sup>3</sup> Several states are considering “gold carding” laws that would require health plans to waive prior authorization on services and prescription drugs ordered by providers with a proven track record of prior authorization approvals. Texas passed a law whereby physicians who have a 90% prior authorization approval rate over a period of six months on certain services will be exempt from prior authorization requirements for those services.

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<sup>1</sup> American Medical Association. Prior Authorization. <https://www.ama-assn.org/practice-management/prior-authorization/prior-authorization>

<sup>2</sup> <https://www.ama-assn.org/system/files/prior-authorization-survey.pdf>

<sup>3</sup> <https://www.aafp.org/dam/AAFP/documents/advocacy/legal/administrative/BKG-PriorAuthorization.pdf>

## Concerns for ASCO Members & the Cancer Community

ASCO members, as well as numerous provider and patient organizations, increasingly cite prior authorization as a significant impediment to patient care.

When prior authorization requests are denied by a payer, providers report that the reason for the denial often is unclear. Failure to provide a detailed response with clear reasons for the denial requires additional follow-up via telephone, facsimile or email and only worsens an already heavy administrative burden on physicians and their staff. If, for example, an oncologist is adhering to ASCO clinical guidelines in the care of a patient but is not aware that the payer bases decisions on different sources of clinical information in its determinations, it significantly impacts the appeals process. Many payers give status updates that simply read, “pending,” with no indication of what further information might be needed for a final decision. Providers have noted that this lack of specific feedback earlier in the process plays a significant role in persistent denials for lack of relevant information, and that this same information provided later in the process often overturns a denial.

Another significant burden within the prior authorization process is “peer-to-peer” communication, usually conducted over the telephone, with the physician sharing more in-depth clinical information with a healthcare provider employed by the payer. For many providers, this is the step in the process that can be the most time-consuming and frustrating, and in many cases the eventual consultation takes place with a non-oncologist.

## Where ASCO Stands

For years, ASCO has advocated at the federal and state level for a more streamlined prior authorization process to stop delays in care that negatively impact patients with cancer and contribute to administrative burden. To this extent, ASCO has long supported state and federal regulations and legislation that seek to set a threshold for prior authorizations where the item or service is approved a vast majority of the time, such as gold carding. ASCO’s 2022 [ASCO Position Statement on Prior Authorization](#) recommends that state and federal governments strengthen oversight and require insurers to implement gold carding when providers have a proven track record of prior authorization approvals.

Gold carding programs have the potential to resolve many provider concerns related to prior authorization. However, monitoring and real-world experience will be required before the cancer care community can consider them a panacea.

## For More Information

[ASCO Position Statement: Prior Authorization \(2022\)](#)

[American Society of Clinical Oncology Position Statement: Pharmacy Benefit Managers and Their Impact on Cancer Care \(2018\)](#)

[Policy Statement on the Impact of Utilization Management Policies for Cancer Drug Therapies \(2017\)](#)