

Key Results of Industry Survey on Prior Authorization

Survey Methodology

- An industry-wide survey on prior authorization practices of Commercial plans was conducted via web-based tool in September-December of 2019.
- The survey sample included all health plans with the Commercial enrollment of $\geq 50,000$ covered lives.

Key Takeaways

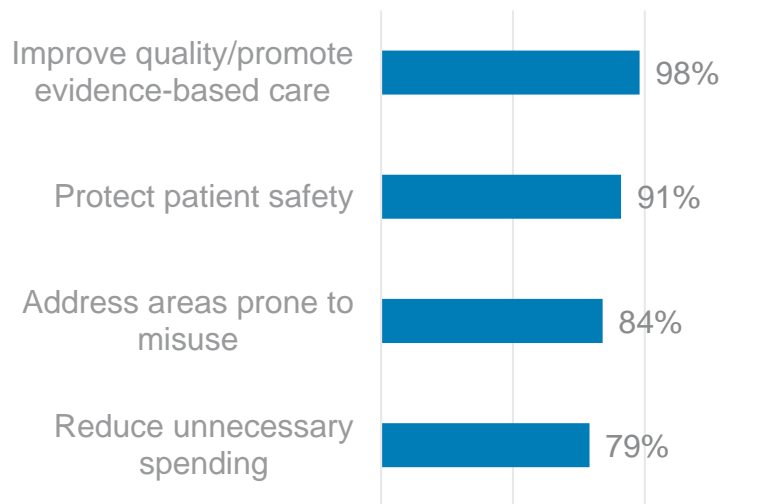
- Industry survey based on responses from 44 plans covering 109 million commercial enrollees.
- Affirms value of prior authorization programs in promoting quality and safety and reducing misuse and waste.
- Highlights evidence-based and targeted nature of programs, use of provider input, and regular review.
- Identifies greatest opportunity for improvement as automation.



Primary Goals of Plans' PA Programs

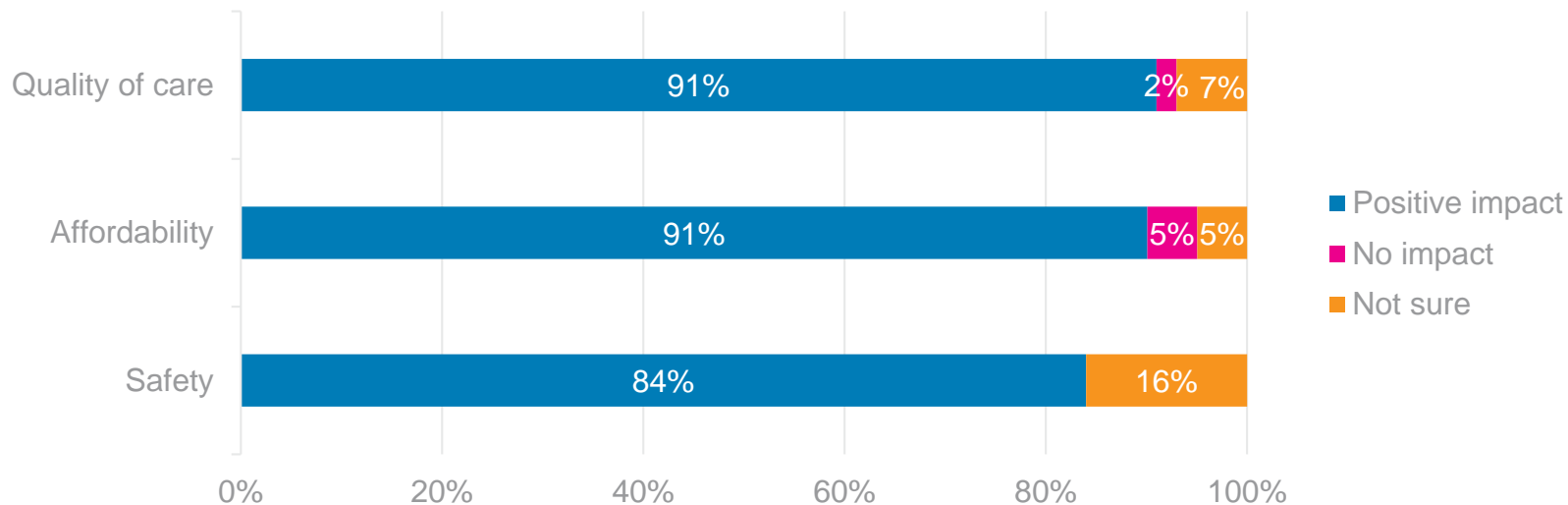
Quality, safety, appropriateness, and affordability are top goals of health plans' prior authorization programs.

The primary objectives of health plans' prior authorization programs



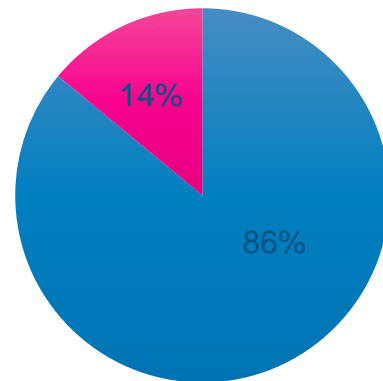
Positive Impact of Prior Authorization Programs

Vast Majority of Plans Report Positive Impact on Affordability, Safety, and Quality of PA Programs



Prior authorization is often part of a broader medical management strategy that includes offering providers evidence-based resources, comparisons to their peers, and incentives to provide value-based care.

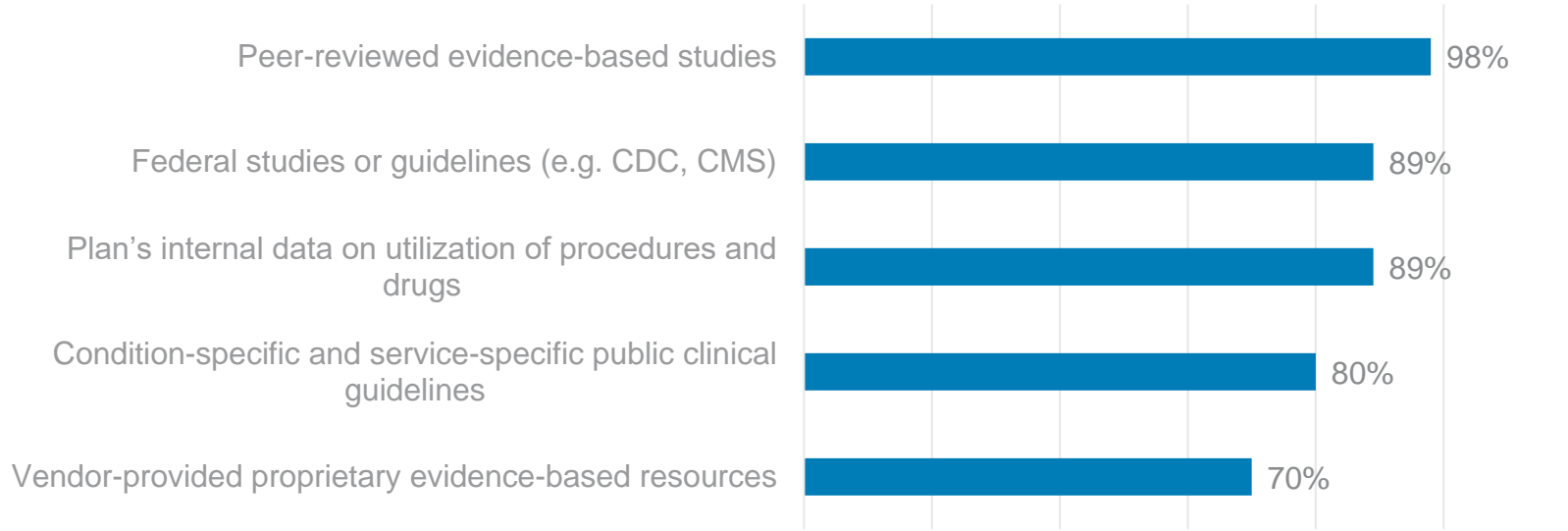
The Vast Majority of Health Plans Use Value-Based Provider Contracts to Incentivize Reduction of Unnecessary Medical Tests, Treatments and Procedures



- Use value-based contracts
- Do not use value-based contracts

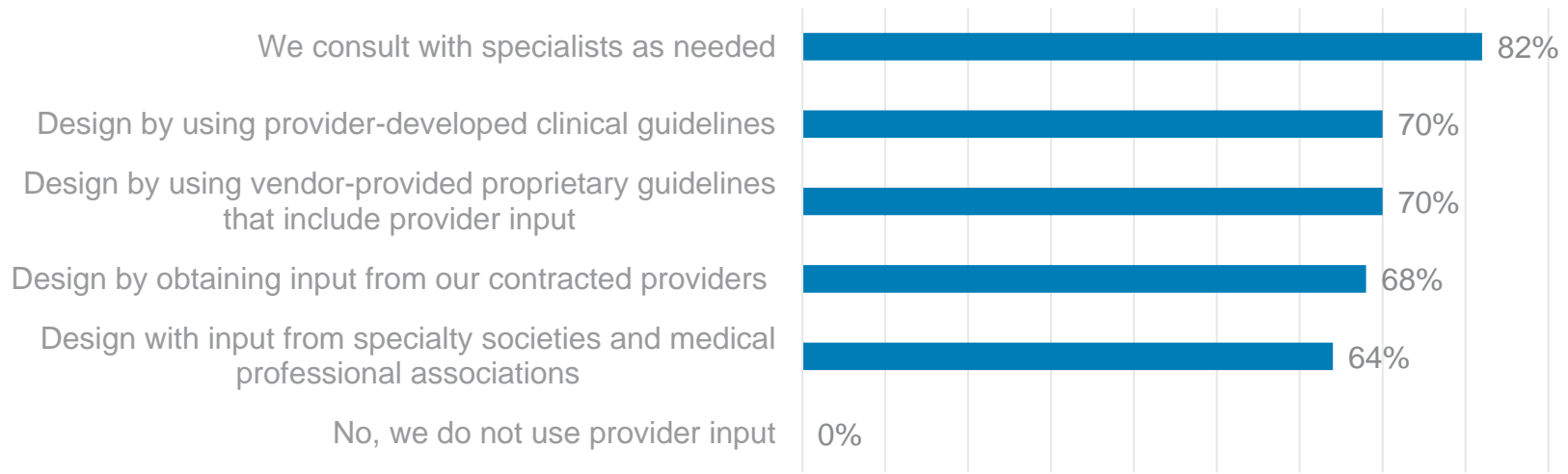
Prior Authorization Programs Are Evidence-Based

When asked what resources are used in designing their prior authorization programs, plans reported using a range of evidence-based resources



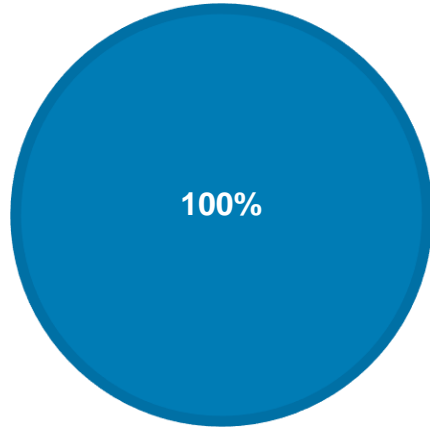
Prior Authorization Programs Use Provider Input

Does your plan get input from providers or provider organizations when you develop the list for drugs and procedures that are subject to prior authorization?

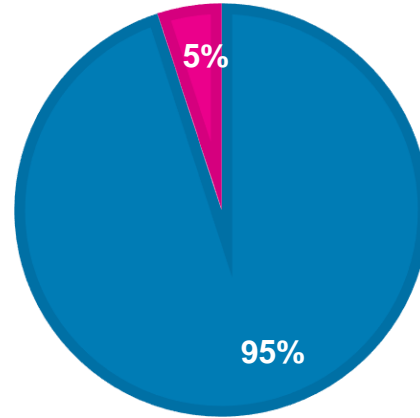


Plans Review their PA Lists at Least Annually

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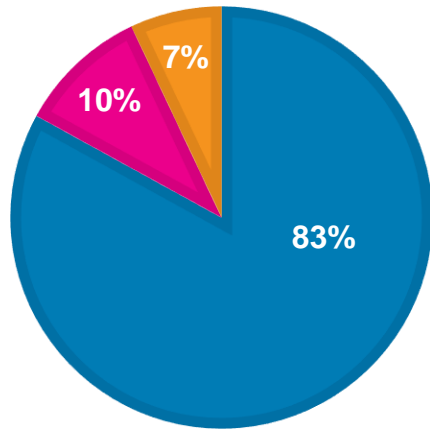
MEDICAL SERVICES



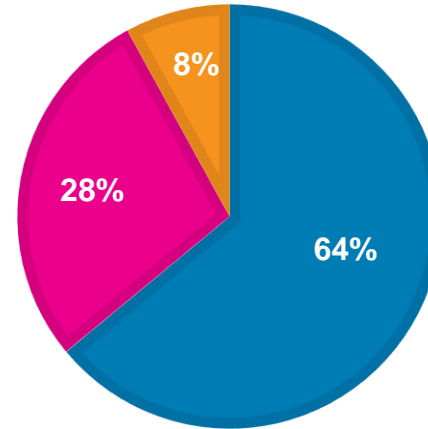
- At least once a year
- Every 2-3 years

Most Commercial Enrollees Are in Plans That Make Only Few Services and Drugs Subject to Prior Authorization

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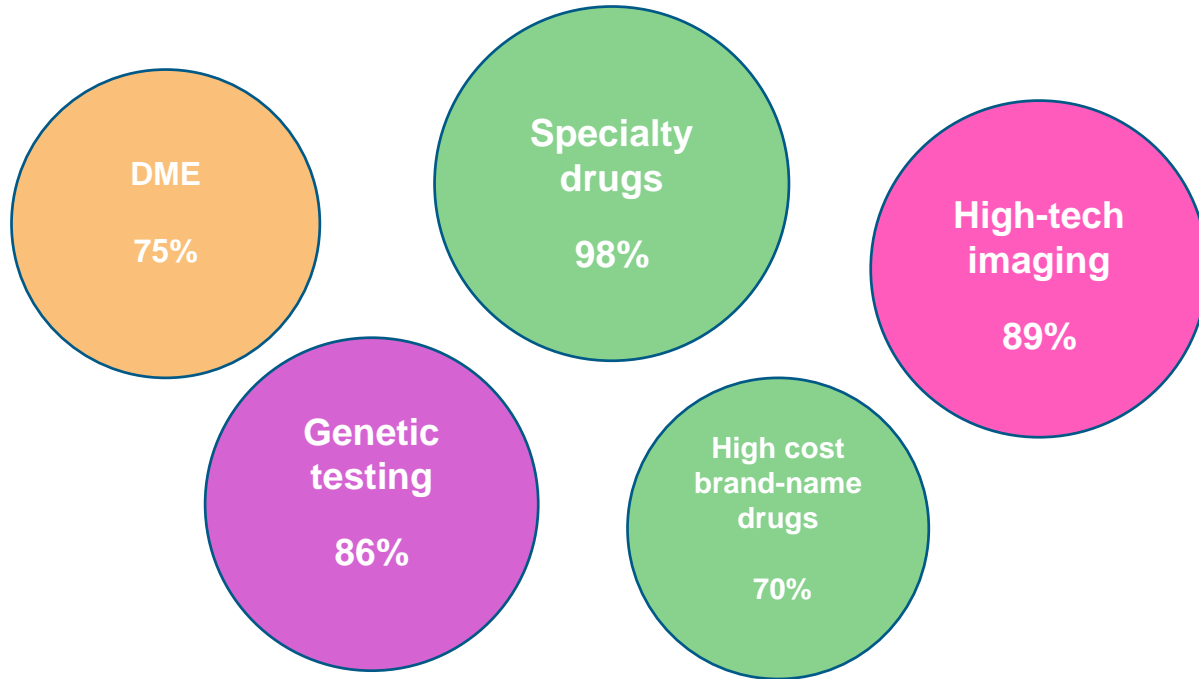


MEDICAL SERVICES



- ≤10% of services/drugs subject to PA
- 11%-24% services/drugs subject to PA
- >25% services/drugs subject to PA

Most Common Treatments Subject to Prior Authorization

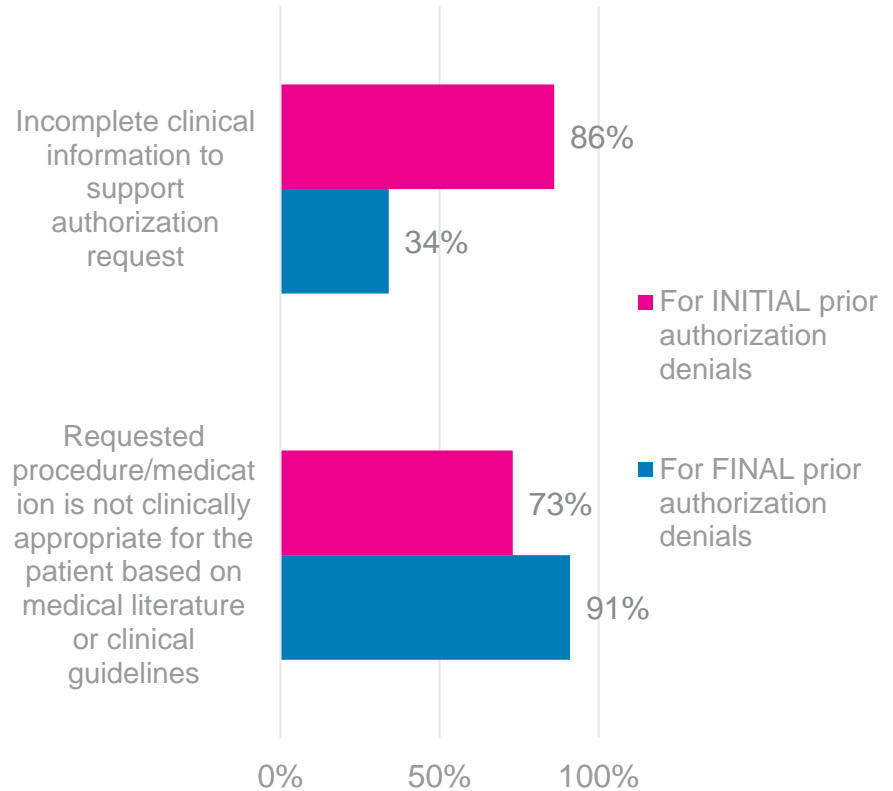


Primary care services: 0%

Incomplete information from providers is the most common reason for an initial denial.

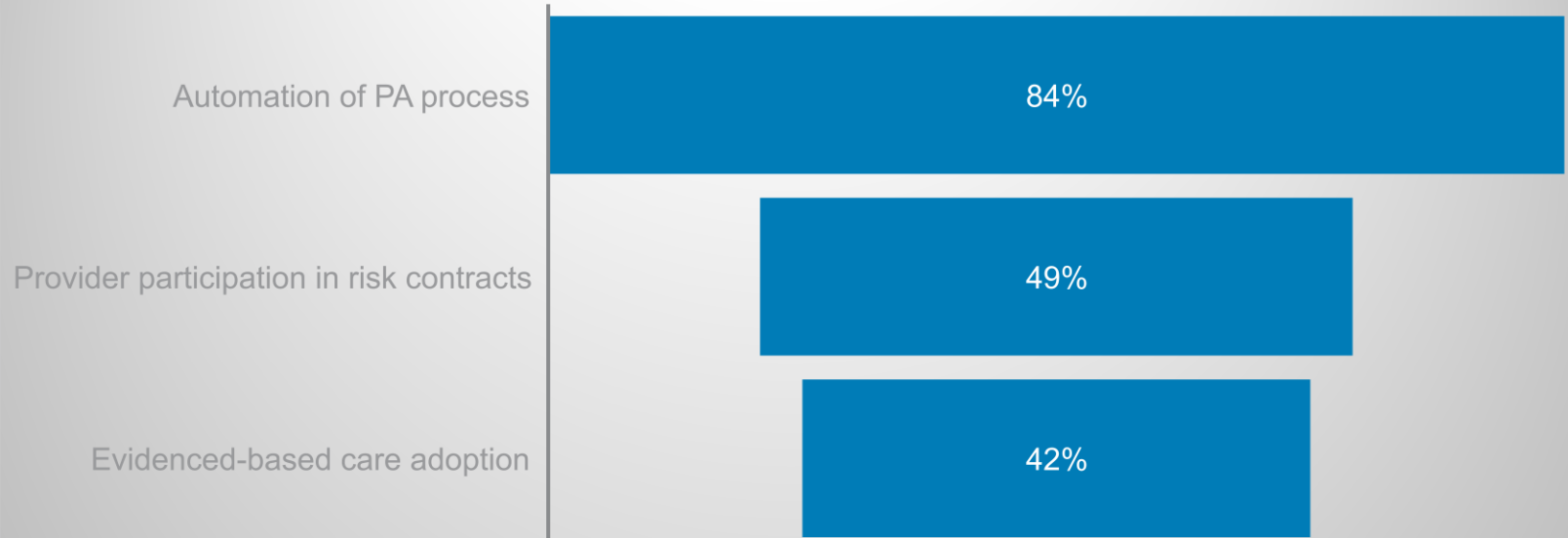
Requested medical service or medication not being evidence-based is the most common reason for a final denial.

Most Common Reasons for Denials



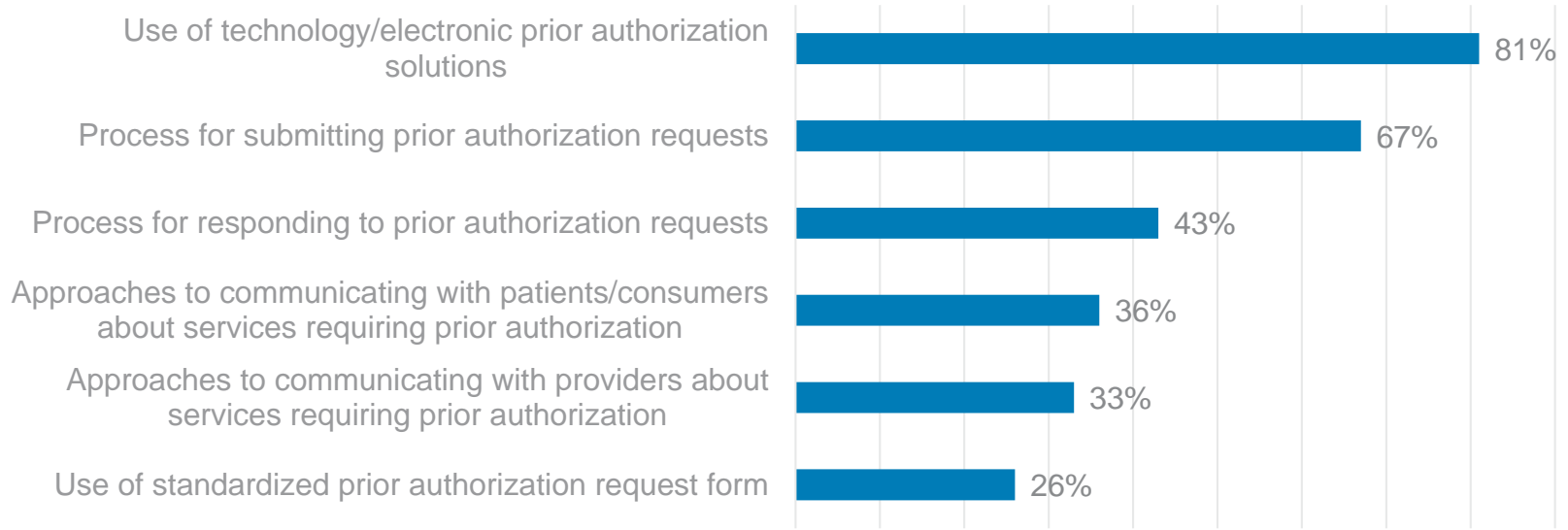
Greatest Opportunities to Collaborate with Providers and Reduce PA Burden

Automation of the prior authorization process is the biggest opportunity for improvement



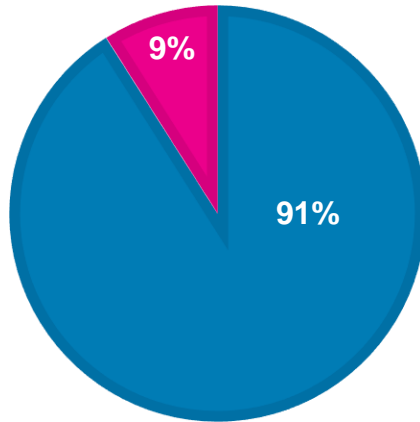
Greatest Opportunities to Reduce Variation in Prior Authorization Programs

Use of technology (ePA) and the process for submitting PA requests are areas ripe for harmonization

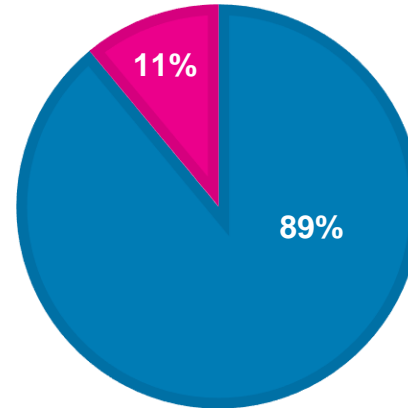


Vast Majority of Plans Streamlining PA Process

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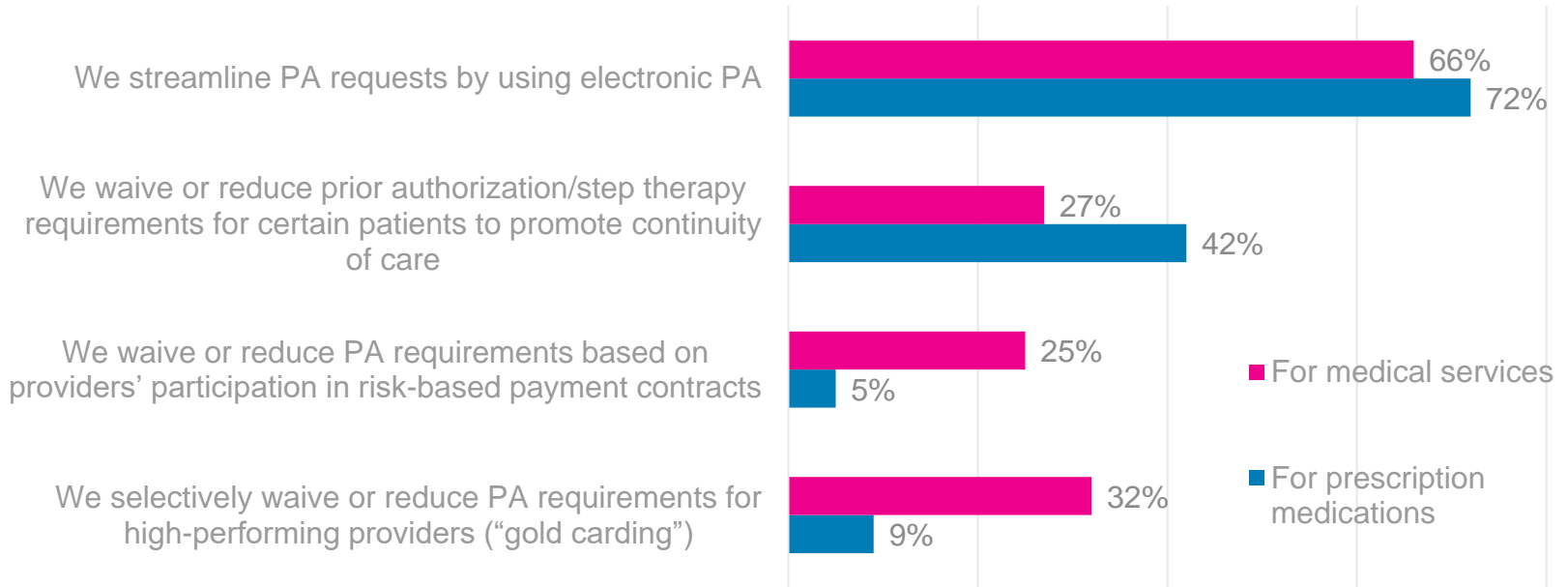


MEDICAL SERVICES



■ Yes
■ No

Majority of Plans Streamlining PA Through Automation



Barriers to Prior Authorization Automation

Providers not using EHRs enabled for electronic prior authorization is the main barrier to greater use of ePA

