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 ≥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.

- Improve quality/promote evidence-based care: 98%
- Protect patient safety: 91%
- Address areas prone to misuse: 84%
- Reduce unnecessary spending: 79%
Positive Impact of Prior Authorization Programs

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

- **Quality of care**: 91% positive impact, 2% no impact, 7% not sure
- **Affordability**: 91% positive impact, 5% no impact, 5% not sure
- **Safety**: 84% positive impact, 16% not sure
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

- 86% Use value-based contracts
- 14% 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.

- Peer-reviewed evidence-based studies: 98%
- Federal studies or guidelines (e.g. CDC, CMS): 89%
- Plan’s internal data on utilization of procedures and drugs: 89%
- Condition-specific and service-specific public clinical guidelines: 80%
- Vendor-provided proprietary evidence-based resources: 70%
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?

- We consult with specialists as needed: 82%
- Design by using provider-developed clinical guidelines: 70%
- Design by using vendor-provided proprietary guidelines that include provider input: 70%
- Design by obtaining input from our contracted providers: 68%
- Design with input from specialty societies and medical professional associations: 64%
- No, we do not use provider input: 0%
Plans Review their PA Lists at Least Annually

PRESCRIPTION MEDICATIONS

100%

MEDICAL SERVICES

At least once a year

Every 2-3 years

95%

5%
Most Commercial Enrollees Are in Plans That Make Only Few Services and Drugs Subject to Prior Authorization

**PRESCRIPTION MEDICATIONS**
- ≤10% of services/drugs subject to PA: 83%
- 11%-24% services/drugs subject to PA: 7%
- >25% services/drugs subject to PA: 10%

**MEDICAL SERVICES**
- ≤10% of services/drugs subject to PA: 64%
- 11%-24% services/drugs subject to PA: 28%
- >25% services/drugs subject to PA: 8%
Most Common Treatments Subject to Prior Authorization

- DME: 75%
- Specialty drugs: 98%
- High-tech imaging: 89%
- Genetic testing: 86%
- High cost brand-name drugs: 70%

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.
Greatest Opportunities to Collaborate with Providers and Reduce PA Burden

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

- Automation of PA process: 84%
- Provider participation in risk contracts: 49%
- Evidenced-based care adoption: 42%
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

<table>
<thead>
<tr>
<th>Opportunity</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of technology/electronic prior authorization solutions</td>
<td>81%</td>
</tr>
<tr>
<td>Process for submitting prior authorization requests</td>
<td>67%</td>
</tr>
<tr>
<td>Process for responding to prior authorization requests</td>
<td>43%</td>
</tr>
<tr>
<td>Approaches to communicating with patients/consumers about services requiring prior authorization</td>
<td>36%</td>
</tr>
<tr>
<td>Approaches to communicating with providers about services requiring prior authorization</td>
<td>33%</td>
</tr>
<tr>
<td>Use of standardized prior authorization request form</td>
<td>26%</td>
</tr>
</tbody>
</table>
Vast Majority of Plans Streamlining PA Process

**PRESCRIPTION MEDICATIONS**
- Yes: 91%
- No: 9%

**MEDICAL SERVICES**
- Yes: 89%
- No: 11%
Majority of Plans Streamlining PA Through Automation

- We streamline PA requests by using electronic PA: 66% (For medical services), 72% (For prescription medications)
- We waive or reduce prior authorization/step therapy requirements for certain patients to promote continuity of care: 27% (For medical services), 42% (For prescription medications)
- We waive or reduce PA requirements based on providers' participation in risk-based payment contracts: 25% (For medical services), 5% (For prescription medications)
- We selectively waive or reduce PA requirements for high-performing providers (“gold carding”): 32% (For medical services), 9% (For prescription medications)
Barriers to Prior Authorization Automation

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

<table>
<thead>
<tr>
<th>Barrier</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider does not use EHR enabled for electronic PA</td>
<td>58%</td>
</tr>
<tr>
<td>Costly/burdensome for payers to enable PA rules and information to be delivered electronically</td>
<td>42%</td>
</tr>
<tr>
<td>Costly/burdensome for providers to buy/upgrade EHR for electronic PA</td>
<td>33%</td>
</tr>
<tr>
<td>Lack of electronic PA solutions on market</td>
<td>30%</td>
</tr>
</tbody>
</table>