



IMPACTS OF PRIOR AUTHORIZATION ON HEALTH CARE COSTS AND QUALITY

A REVIEW OF THE EVIDENCE

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Preface

This brief summarizes the use of prior authorization policies for coverage of health care goods and services and reviews the evidence on cost and quality impacts of these policies. The review was conducted by Ani Turner, Samantha Clark, and George Miller of Altarum's Center for Value in Health Care, with funding from the National Institute for Health Care Reform.

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Summary of Findings

- ▲ Prior authorization (PA) policies are used to varying degrees by both public and private payers to manage the use of costly or potentially avoidable care. Prescription drugs, durable medical equipment, and diagnostic radiology are common targets.
- ▲ Providers find PA to be a burden that has been increasing. Payers believe PA policies are necessary and effective and continue to invest in the infrastructure to implement them.
- ▲ Potential benefits of PA include reduced provision of avoidable or non-value-added care, a reduction in health spending or a shift of resources to higher value care, an acceleration in adoption of new standards of care, and the prevention of fraud or abuse.
- ▲ Potential costs of PA include payer and provider implementation costs in staff time and technology, reduction in provider time available for patient care, provider resentment, patient frustration, and poorer quality outcomes due to delayed or abandoned care.
- ▲ A moderate number of studies have been published on the impacts of PA. Prescription drug applications have been studied the most. The research generally shows reduced use of the targeted care, sometimes with offsetting increased use of preferred treatments. Evidence also shows reduced spending on the targeted care, although this does not always translate into lower overall health care spending. Positive outcomes have been shown under PA programs for diagnostic imaging, where high rates of use and cost were reduced, and opioid prescribing, where rates of subsequent opioid abuse and overdose were reduced.
- ▲ There is evidence that PA can delay receipt of care or result in patients abandoning prescribed care. The extent to which either negatively affects patient outcomes is less clear. Physicians surveyed believe a large percentage of patients are negatively impacted, but we found little research establishing specific adverse medical outcomes, particularly downstream. There is some evidence that PA policies for use of atypical antipsychotics to treat serious mental illness increase the risk of treatment discontinuation, although one study found better health outcomes under this application of PA.
- ▲ Provider groups such as the American Medical Association have raised concerns about the time and cost burdens of PA. Estimates of the cost burden to physician practices vary considerably, from \$80,000 annually per physician to between \$2,200 and \$3,400 annually per physician (2010 dollars). We find the direct cost of PA likely to be closer to the lower end estimates, which were focused specifically on PA interactions with insurers and were based on staff time requirements recorded in real time, rather than on requirements estimated by providers from memory. Use of electronic health records has been shown to reduce provider time requirements.
- ▲ Research has not yet definitively established (1) the **net** economic impact of PA across all system costs and benefits and (2) the downstream health impacts. For today, standardizing, streamlining, and automating the process and targeting the requirements are consensus approaches to decreasing the burden, thus increasing the net benefit of these programs.



1 Use of Prior Authorization

Prior authorization (PA) is the most common utilization management tool used by health care payers in the U.S. This report summarizes the use of prior authorization, current evidence on cost and quality impacts, and emerging strategies for increasing the net benefit of PA policies. The findings are based on a review of the peer-reviewed and gray literature and interviews with industry experts, as documented in Appendix A.

1.1 PRIOR AUTHORIZATION DEFINED

Prior authorization – also known as precertification, preauthorization, prior approval, prior notification, prospective review, and prior review – requires health care providers to establish eligibility and obtain approval from the patient’s health plan before care is delivered to qualify for payment. Payers use PA as a strategy to reduce utilization of overused or low-value services, reduce spending, and improve care quality.¹

Health care payers employ physicians, nurses, and other health care professionals to support the development and execution of PA policies. These policies are routinely updated based on new treatments and medical guidelines, and their application can accelerate the adoption of new standards of care.

The types of care that require PA vary by payer, based on utilization patterns, clinical evidence, financial considerations, and government regulations and statute. This lack of consistency is one of the challenges facing providers in meeting PA requirements. Common types of care requiring PA include prescription drugs, durable medical equipment, diagnostic radiology, surgical procedures, inpatient stays, and behavioral health treatments. Pharmacy benefit managers, under contract to health plans, often play a role in PA programs for prescription drugs. With the introduction of a new generation of highly targeted and expensive drug therapies, drugs are likely to remain an area of focus for PA.

Step therapy, also known as “fail first,” is an extension of PA and a common formulary tool used to manage prescription drug use. Step therapy requires that patients try lower-cost drugs – usually biosimilars or generics – before a costlier or brand name drug will be covered.² If the patient responds well to the lower-cost option, the patient, provider, and payer continue with that prescription. Step therapy is often applied to drug treatments for cancer, mental health disorders, pain, HIV, and Hepatitis C.³

1.2 THE PRIOR AUTHORIZATION PROCESS

The process of applying for and receiving PA varies by payer, but generally involves obtaining the payer’s PA form, completing all required clinical and administrative information, submitting the form to the health plan, and, if needed, contacting service representatives or other personnel at the plan for follow up.



The PA process may or may not be automated, depending on the practice's use of electronic medical records, the capabilities of their EMR system, and the payer's ability to support electronic PA. Other common methods for submission of PA requests include fax, secure email, phone, and use of the payer's digital portal.

Once a PA request is submitted, it is reviewed by trained clinical staff such as pharmacists or registered nurses and approved or denied. The length of time before requests are processed varies by type of care, payer type, use of automation, and other factors, ranging from same day to several days.

When a PA request is denied, providers and patients have the option to appeal; under the Affordable Care Act, all health plans are required to have such an appeal process. In many cases, authorization is denied due to incomplete information, and requests are often approved once submission errors are remediated. If the initial denial is upheld, providers and patients may request an external appeal by an independent third-party reviewer. An expedited review may be requested under situations of medical urgency.⁴

Physicians have reported that, overall, 72% of PA requests are approved on initial request and an additional 7% are approved on appeal.⁵ PAs are typically only valid for a specified length of time, after which additional requests must be submitted for continued prescription refills or therapies.

1.3 PRIOR AUTHORIZATION IN MEDICARE AND MEDICAID

While commercial insurers have been implementing PA policies for many years, the use of PA under Medicare has historically been limited. Recent demonstration programs and the growing role of managed care organizations in delivering care to Medicare and Medicaid enrollees are expanding the use of PA for the publicly insured.

Medicare beneficiaries have the option to enroll in traditional Medicare, paid on a fee-for-service basis, or in a Medicare Advantage (MA) managed care plan. Traditional Medicare was historically restricted from imposing PA requirements under the Social Security Act (SSA). In recent years, the SSA was amended to allow PA to be tested and evaluated under Medicare fee-for-service for several categories of care, including repetitive, scheduled, non-emergency ambulance transport, non-emergent hyperbaric oxygen, home health care, and power mobility devices. Stemming from these demonstrations, systemwide PA requirements have been implemented for power mobility devices; CMS maintains a [Required Prior Authorization List](#) of specific requirements.

Unlike traditional Medicare, under Medicare Advantage, the managed care plans have more flexibility to implement PA policies. If an MA plan requires enrollees to get prior approval for a service, and if approval is denied, then the plan generally will not cover the cost of the service.

A study of the use of PA in Medicare Advantage found that eighty percent of enrollees in MA plans are in plans that require PA for at least one Medicare-covered service.⁶ Seventy percent of enrollees are in plans that require PA for durable medical equipment, Part B drugs, skilled nursing facility stays, and inpatient hospital stays. Sixty percent are enrolled in plans that also require PA for ambulance services, home health care, certain medical procedures, and lab tests. Over half of MA plans require PA for mental health services.



MA enrollment has been growing relative to traditional Medicare. The Kaiser Family Foundation reports that, as of 2019, one-third of Medicare enrollees are in an MA plan. Enrollment in MA has been increasing by 8% per year and is projected by the Congressional Budget Office to represent nearly half of all Medicare enrollees in the next ten years.

Medicaid, as a joint federal and state program, gives states some authority to establish their provider payment rates and cost sharing requirements, and to impose utilization controls. States vary in their use of PA and the services to which it is applied. In addition, most states (35 out of 51) contract with MCOs to manage care and reimburse providers, paying the MCO a capitated rate for their enrolled population. Under the Medicaid MCOs, PA requirements are established by the contractors, although some states create consistency through the requirements written into their managed care contracts. For example, fourteen states include a uniform preferred drug list in their managed care contracts to guide the MCOs' PA policies.⁷

Recent comprehensive reviews of the use of PA in publicly funded programs have recommended expansion of these programs. The Government Accountability Office recommended that CMS work to increase oversight of the use of PA in Medicare and Medicaid plans and to expand use of PA to additional items and services with high utilization and high payment rates.⁸ In a 2018 report, the Medicare Payment Advisory Commission recommended that the traditional Medicare program more broadly adopt tools used effectively by MA and other health plans to reduce low-value care, including PA, clinical decision support and provider education, and more accountable provider payment models.⁹

2 Evidence of Impacts on Health Care Use and Spending

There are a modest number of studies on the impacts of PA programs on health care utilization and spending. Prescription drug applications have been received the most study. Some research has also examined use of PA for imaging, medical devices, transportation, and other therapies.

The research shows that PA programs reduce utilization of the targeted treatment, sometimes with offsetting increased use of preferred treatments. The evidence also shows PA programs generally reduce spending on the targeted care, although where overall health care costs are tracked, the PA-focused reductions do not always translate to lower overall health spending.

While the evidence base is not substantial enough to draw firm conclusions, PA effectiveness has varied by the type of care to which it has been applied. Brief summaries of selected research findings on the impacts of PA on health care use, cost, and quality for various types of care follow.

Medical imaging. There is evidence that PA for medical imaging can be effective in reducing utilization and associated health care costs. Multiple studies have found PA policies were associated with reduced use of magnetic resonance imaging, computer-aided tomography scanning, and cardiac imaging.¹⁰



Hyperlipidemia and hypertensive medications. PA was analyzed for lipid-lowering medications in Michigan and Indiana dual Medicaid and Medicare enrollees. In Michigan, PA reduced use of non-preferred medications by 58%, with an associated increase in preferred agents. In Indiana, which started with less use of non-preferred drugs, there was a smaller impact. Modest cost reductions were noted.¹¹

Atypical antipsychotic medications. There are multiple studies on PA for atypical antipsychotic (AAP) medications. Such studies consistently find reductions in AAP use and in drug spending per patient. However, the evidence goes both ways on the impact on total health care costs and on indicators of patient outcomes. A 2016 literature review of the impact of restricted access to AAPs for bipolar disorder or schizophrenia found most studies showed a reduction in pharmacy costs, but most did not measure whether costs were simply shifted to hospitalizations or emergency department (ED) visits due to an increase in treatment discontinuation or other undesirable outcomes.¹²

Opioid prescribing. PA for opioid prescribing has been shown to reduce rates of abuse and overdose. A study compared outcomes for Pennsylvania Medicaid beneficiaries with low, high, and no PA for opioid medications. The study found that enrollees in plans with both low and high PA programs had lower rates of abuse and overdose than those in no PA plans.¹³

Power Mobility Devices. CMS has introduced several demonstrations testing PA policies under traditional Medicare for select goods and services. These policies were first launched in 2012 with a focus on PA for power mobility devices (PMD). The PMD demonstration applied to fee-for-service beneficiaries in seven states that were known for high rates of errors and fraud. In its first year, this demonstration decreased monthly expenditures from \$12 million to \$3 million without impacting beneficiary access to power mobility devices that were deemed medically necessary to appropriate populations. Following the success of this demonstration in its first year, the demonstration was expanded to a total of 19 states throughout the country.¹⁴

Non-emergency medical transportation. A CMS demonstration project of the use of PA for repetitive, scheduled, non-emergency ambulance transport (RSNAT) was implemented in December 2014. A repetitive ambulance service was defined as “a medically necessary ambulance transportation that is furnished in three or more round trips during a 10-day period, or at least one round trip per week for at least three weeks.” According to the first evaluation, the model reduced RSNAT service use and expenditures for end-stage renal disease (ESRD) beneficiaries across the eight model states and DC in 2015 and 2016, with an estimated average reduction of 2.5 RSNAT trips and \$432 in RSNAT expenditures per ESRD beneficiary per quarter.¹⁵

Non-emergent hyperbaric oxygen. A CMS demonstration of PA use for non-emergent hyperbaric oxygen (HBO) therapy ran from March 2015 to March 2018. HBO therapy is a treatment that exposes the entire body to oxygen under increased atmospheric pressure and can be provided in an outpatient facility or hospital. An evaluation of the demonstration showed the program modestly decreased expenditures for non-emergent HBO therapy in model states by about \$5.33 million over the first 13 months.¹⁶



Specialty drugs. Spending on specialty medications is growing by more than 15% annually. As of 2018, it accounts for approximately half of total annual pharmacy spending, or \$235 billion.²⁴ Those who prescribe, dispense, deliver, and pay for specialty medications use a combination of traditional and novel management approaches, such as PA, step therapy, and tiered formularies, to manage costs.

PA and step therapy are used by at least one of 10 Medicare Part D plans for 80% of the covered specialty medication drugs. It is the largest utilization management tool used for prescription medication and is successful in containing costs while ensuring that those who need expensive and specialty medication can receive it. Most payers also institute a maximum amount for which patients are responsible in terms of out-of-pocket costs. This can, however, be as much as tens of thousands of dollars per year per patient. Step therapy has been found to reduce insurer costs by 9% to 11%. PA decreases prescribing rates and reduces drug costs by shifting from non-preferred to preferred drugs.¹⁷

Generic versus new or branded drugs. A trial in the treatment of rheumatoid arthritis published in the New England Journal of Medicine compared the efficiency of a combination of three generically available, oral disease-modifying antirheumatic drugs with that of a combination of an injected biologic drugs and oral methotrexate in patients who had previously failed with methotrexate alone. The authors found the regimen of three generic drugs to be no less effective than the combination of the biologic and oral methotrexate and suggested that the generic regimen be tried before use of a specialty medication was initiated. These findings endorse the use of step therapy to promote the prescribing of generics as first-line treatment for rheumatoid arthritis and for drugs for other conditions and medical needs before resorting to higher-price injectable specialty medications.

Additional clinical requirements. Payers sometimes impose additional clinical requirements as a pre-condition to granting PA. These requirements can cause a net increase in the costs associated with providing the requested service, as seen in the following example.

In a 2016 observational study, researchers evaluated the impact of PA program implemented by Priority Health, a west Michigan private health insurance company. The study aimed to evaluate the plan's prior authorization procedures for low-back pain in a non-Medicare population by assessing changes in pre-surgical non-operative care, lumbar fusion trends, and overall back surgery rates compared with another health plan with a similar program, and with national benchmarks. Priority Health's PA policies mandated that each patient have a consultation with a psychiatrist before a surgical consultation. After initiation of this policy in December 2010, lumbar fusions decreased from 76.3 out of 100,000 in 2010 to 62.6 out of 100,000 in 2011, but with subsequent increases to 64.2 and 73.8 in 2012 and 2013. For members who had lumbar fusion, per-member, pre-surgical costs increased by \$2,233 with the psychiatrist preauthorization and an additional \$1,370 with implementation of an additional lower-back pain surgery PA implemented in 2013. These programs were associated with the unintended consequence of increased costs due to more non-operative care and only a temporary reduction in the lumbar fusion rates.¹⁸



3 Evidence of Burdens of Prior Authorization

Potential burdens of PA include payer and provider technology and staff time for implementation, reduction in provider time available for patient care, delays in care, provider resentment, patient frustration, and poorer outcomes for some patients due to delayed care or care not received. Some evidence on provider administrative burdens and delays in care are discussed below.

3.1 PROVIDER TIME AND OPERATING COSTS

Providers quite naturally oppose administrative involvement in their care planning and the hassle of navigating payer-specific PA policies. The 2018 AMA Prior Authorization Physician Survey surveyed 1,000 physicians nationwide to assess the impact of PA. This twenty-nine-question survey included both primary care physicians (40%) and specialists (60%) and indicated that providers completed on average 31 PAs a week.¹⁹

Physicians overwhelmingly report that PA has been increasing over the past five years. Half of providers surveyed said that the burden of PA has significantly increased in the last five years, and another 38% said the burden had increased somewhat. One-third of those surveyed indicated that they had hired or assigned staff to process the large volume of PAs they handle each week. Nearly all physicians (86%) classified the burden associated with PA for their practice as is either high or extremely high.

Estimates of the cost burden to physician practices vary considerably, from \$80,000 annually per physician²⁰ to between \$2,200 and \$3,400 annually per physician (2010 dollars).²¹ We find the direct cost of PA likely to be closer to the lower end estimates, which were focused specifically on PA interactions with insurers and were based on staff time requirements recorded in real time, rather than on requirements estimated by providers from memory. Use of electronic health records has been shown to reduce provider time requirements.

3.2 DELAYS IN PATIENTS RECEIVING CARE

Another potential burden of PA is the delay in patients receiving treatment. Many patients who are denied a PA for a prescription or other medical service are never offered an alternative treatment option, and the appeal process can be long and complicated.

In 2018, physicians surveyed reported receiving a response within one business day for just under half of all PA requests (48%). Another 19% of requests received a response in two days, and 26% required three business days or longer (7% reporting not knowing average wait times).²²

3.3 POORER HEALTH OUTCOMES

PA policies can be thought of as enforcing the payer's eligibility criteria prior to care being delivered. These criteria should be based on the best current medical practice guidelines. While in general, denial of ineligible care ahead of time should not adversely impact health, there are a few ways that PA policies could lead to poorer health outcomes.



First, the process itself may delay the delivery of care that meets criteria for good medical practice. These delays may be especially lengthy and impactful where there are errors in processing the PA request or denials that are eventually overturned.

Second, the delays, additional requirements, and associated confusion can interrupt the treatment process and even lead to patient abandonment of treatment. For example, a study published in the *Journal of Managed Care Pharmacy* examined the records of more than 4,000 patients with Type 2 diabetes who were prescribed costly, newer medications requiring PA. Those who were denied the medications had higher overall medical costs during the following year.²³ Failure to receive and take medically necessary medications could be a factor contributing to inadequate control of diabetic conditions, which may result in an excess of resource utilization and increase costs for treating the disease and other comorbidities.

As noted in the previous section, results are also mixed on the impact on health outcomes of PA for antipsychotic drugs, with some evidence that the risk of treatment abandonment increases. Two notable examples of these mixed findings follow.

- ▲ A study of PA applied to antipsychotic drugs for schizophrenia in the Georgia Medicaid program found both reduced utilization and better health, measured as avoidance of ED visits and hospital admissions, lowering drug costs and total Medicaid program costs.²⁴
- ▲ A study of PA applied to second-generation antipsychotic and anticonvulsant drugs for those with bipolar disorder in the Maine Medicaid program found an eight-percentage-point reduction in use of these drugs but no increase in use of preferred agents. The study found a small decrease in total drug spending for bipolar disorder (\$27 per patient) but a significant increase in risk of treatment discontinuation.²⁵

Of course, reducing unnecessary utilization is one of the objectives of these policies. The question is whether the abandonment of the prescribed treatment leads to poorer health outcomes. More work is needed to follow the impacts of PA on immediate and especially downstream health outcomes.

4 Strategies to Improve Prior Authorization

Reducing the time and cost burden to providers and patients through standardization, process automation, and informed targeting of requirements can increase the net benefit of PA programs.

In January 2018, the American Hospital Association, America's Health Insurance Plans, American Medical Association, American Pharmacists Association, Blue Cross Blue Shield Association and Medical Group Management Association released a consensus statement outlining their shared commitment to pursue strategies to improve the PA process.²⁶ These organizations agreed to work together to:

- (1) reduce the number of health care professionals subject to PA requirements based on their performance or participation in value-based agreements.
- (2) regularly review and update the services and medications that require PA;



- (3) improve communications among insurers, providers, and patients regarding PA;
- (4) protect continuity of care for patients on ongoing treatment programs; and
- (5) accelerate industry adoption of national electronic standards for PA and the availability of information on requirements at the point of care.

We provide examples of specific strategies being explored and implemented today within each of these categories.

4.1 STANDARDIZATION

One of the largest complaints made by providers and medical office staff is the lack of consistency in the PA process by payer. Physician groups such as the AMA have pushed to improve the PA process by increasing consistency and standardization across payer groups. Payers share these goals and are working internally to streamline the PA process.

Standardization of Services Covered

Physicians, through the AMA, have sought to standardize services requiring PA. Creating a standardized list of services that must go through a PA process for all payers would help to reduce the time burden and administrative frustrations. Given the differences payers face in populations served, patterns of spending, state and federal laws and regulations, and other pressures, it may not be feasible to develop a single standardized list of types of care requiring PA, but any movement toward greater consistency across payers would bring greater efficiency and less uncertainty to providers.

Of the 39 states contracting with managed care organizations for Medicaid coverage, 14 reported mandated use of a managed care uniform Preferred Drug List by which the state identifies drugs for which a PA is not required.²⁷

Standardization of Submission Processes

Even when payers require PA for the same medication or service, the required process for submission may vary. Those who work to submit PA requests have expressed concern that there is not a standardized submission process for PA, leading to the creation of too many workflows, workarounds, and delays in PA submission. Often, approvals of authorization requests are delayed due to missing information. Consistency in submission processes would make it easier to develop manual or automated systems to meet information requirements and reduce such delays.

4.2 AUTOMATION

While automation does not reduce the number of PAs, it can make the processing of PAs less burdensome and more uniform across health plans and pharmacy benefit managers. Providers who exclusively use an electronic method for PA requests have reported spending on average 2.5 fewer hours on PA each week. However, few providers find themselves exclusively using a single solution, with 76% reportedly using more than one channel to complete PA requests.



Automation is needed for both the coverage inquiry process and the PA submission process. The health care industry is working to establish a new standard to support real time inquiry regarding coverage of prescriptions and medical services. Once implemented across payers, pharmacies, providers, and vendors, providers will be able to determine which prescriptions and services are covered at the time of care. If it is determined that PA is required, process automation can also support the auto-population of PA requests with patient and clinical data from the electronic health record, reducing the time required to create a submission.

The growth of electronic prescribing offers opportunities for greater automation of the PA process for prescription drugs. Many states have already implemented online systems to receive drug PA requests electronically. However, the meaning of “electronic” PA can vary widely from state to state, including everything from standard electronic transactions to health plan portals to even faxes. The number of states mandating electronic PA is expected to grow rapidly as PA utilization continues to increase.

According to a current industry scorecard, nearly all commercial payers (96%) support electronic PA.²⁸ Providers are the constraint to greater adoption, with only 48% of providers able to implement electronic PA. Many electronic health record (EHR) systems already have electronic prescribing capabilities that can process electronic PA for pharmacy services, and work is progressing on EHR systems supporting electronic PA for medical services.

The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act signed into law in October 2018 contains a provision requiring implementation of electronic PA for drugs covered under Medicare Part D by January 1, 2021. The law requires that CMS implement this provision by working with standards organizations and developing regulations mandating that Medicare Part D plans accept PA requests submitted electronically.

Recently proposed legislation in the U.S. House of Representatives is evidence of continued interest in PA process improvements at the federal level. On June 5th, H.R 3107: The Improving Seniors Timely Access to Care Act of 2019 was introduced. This bipartisan bill is centered on advancing standardization and transparency around the implementation of PA by Medicare Advantage plans so that such policies achieve their goal of preventing unnecessary care while promoting safe and evidence-based care. The bill requires CMS to regulate the use of PA by Medicare Advantage plans, including establishing a process to make “real-time decisions” for services that are routinely approved. MA plans would be required to offer an electronic PA process and report to CMS on how extensively they use PA, as well as how often they approve or deny medications and services.

4.3 STRATEGIC APPLICATION OF PA REQUIREMENTS

The net benefit of PA programs will be increased if they are strategically applied where most necessary. In circumstances where nearly all authorization requests are being approved, little benefit is being gained to offset the additional administrative burden imposed.



Plans have begun lifting requirements for PA where experience shows they are less needed. Continual assessment of approval rates and adjustments in requirements by type of care and by payer can lead to programs that are better targeted and less costly.

Prior Authorization Sunset Programs

Prior authorization “sunset” programs allow health plans to lift PA requirements on drugs or services for which a significant majority of PA requests are being approved. This practice reduces the burden on both payers and providers. It may be desirable to track or periodically examine utilization after requirements are lifted to ensure that care patterns remain appropriate without monitoring.

Gold Card or Exclusion Programs

“Gold card” programs allow physicians with high rates of PA approvals over a specified period to be exempt from PA requirements. This would seem to be a mutually beneficial approach – health plans meet resource utilization goals and reduce administrative burdens, and physicians following health plan criteria are excused from PA. However, America’s Health Insurance Plans (AHIP), an association of major health insurers in the U.S., favors an emphasis on process automation rather than “gold carding” to ease the burden of PA. AHIP reports that payers experience challenges with “gold carding,” including the following:²⁹

- ▲ Performance tends to slip once the provider has gold card status
- ▲ Performance typically varies across services, so it is difficult to confer gold card status on a provider across all services
- ▲ Providers within the same clinic or group often perform differently
- ▲ Granting gold card status potentially conflicts with state laws that preclude treating enrollees differently
- ▲ The payer’s authorization and claims systems are not always configurable to support different workflows for different providers.

4.4 PROVIDER PROCESS IMPROVEMENTS

Providers can also develop and implement process improvements to reduce the burden of PA. One non-profit physician network of nearly 1,800 providers in Massachusetts found that using certified pharmacy technicians for PA saved physicians about 40 hours a year and reduced the amount of time to research and submit a prior approval to 28 minutes.³⁰ Other studies have found that use of a centralized clinical team to handle PAs reduced time and resources required.³¹



5 Summary and Observations

It is generally understood that prior authorization is a necessary feature of medical care management. PA can reduce avoidable care while helping to control health care expenditures. It can also hasten adoption of new standards of care. On the other hand, the process imposes time and cost burdens, can result in delays in needed care, and causes confusion and often frustration for providers and patients. The current literature on PA finds evidence of both savings and burdens but stops short of a combined cost-benefit analysis.

Payers clearly believe the benefits of PA outweigh the additional administrative costs, or they would not be increasing their use of these policies and continuing to invest in process improvements. For providers, PA would appear to impose costs with few benefits, requiring them to justify their patient care plans, devote additional clinical and administrative resources, and potentially delay care to their patients. Providers, however, have historically been insulated from cost or value considerations, and may move slowly to change practice patterns or reduce delivery of low value care.³²

Whether reducing health care spending or increasing medical practice expenses, ultimately both the costs and the benefits associated with these programs are borne by all of us as patients, employees, and taxpayers. The goal is to refine PA policies and processes so that they retain their benefits while minimizing the associated burdens. It is encouraging to see legislative action and health care industry activities around standardizing, streamlining, automating, and targeting PA requirements, which will only increase the net benefit of these programs.



Appendix A: Methods

Our sources for this review of prior authorization were the peer-reviewed literature, gray literature including reports by the Medicare Payment Advisory Commission, the Government Accountability Office, and the American Medical Association, and a series of interviews with insurance and pharmaceutical industry experts.

We performed a systematic review of the peer-reviewed and gray literature using PubMed, Google Scholar, and the University of Michigan Library databases using search terms including “prior authorization”, “utilization”, “impact”, “payer”, “pharmaceutical”, “step therapy”, “Medicaid/Medicare”, “economic”, “low-value care”, “delay”, and “health outcomes”. We focused on literature from 2009 forward, with greatest emphasis on evaluations of interventions, data, and policies within the past five years. We strived to gather literature that was representative across settings, payers, and health care specialties. We examined objectives, data sources and methodologies, internal validity, research design, and outcomes to determine the quality and adequacy of the literature reviewed. We gathered a total of 118 journal articles and other sources, of which those cited in the body of this report were found to be most relevant.

To supplement our review of the literature, the project team interviewed the following industry experts for their on-the-ground knowledge of the use, trends, costs, and benefits of PA.

Date of Interview	Name	Title	Organization
May 1, 2019	John Keats	Market Medical Executive	Cigna Health Care
May 23, 2019	Rena Conti	Associate Professor of Markets, Public Policy and Law	Boston University, Questrom School of Business
June 6, 2019	Mark Fendrick	Director	Center for Value-Based Insurance Design
June 11, 2019	Connie Hwang	Chief Medical Officer	Alliance of Community Health Plans
June 11, 2019	Anthony Montoya	Public Policy Director	Alliance of Community Health Plans
June 26, 2019	Kate Berry	Chief Medical Officer	America's Health Insurance Plans



Endnotes

¹ American Medical Association. Prior authorization: The current landscape. https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/premium/psa/prior-authorization-toolkit_0.pdf. Published 2015. Accessed May 20, 2019.

² PatientEngagementHIT. How Does Step Therapy Impact Patient Care Access, Costs? <https://patientengagementhit.com/news/how-does-step-therapy-impact-patient-care-access-costs>. Published August 8, 2018. Accessed May 20, 2019.

³ Nayak RK, Pearson SD. The ethics of 'fail first': guidelines and practical scenarios for step therapy coverage policies. *Health Affairs (Project Hope)*. <https://www.ncbi.nlm.nih.gov/pubmed/25288422>. Published October 2014. Accessed July 30, 2019.

⁴ American Medical Association. Prior authorization toolkit - ama-assn.org. https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/premium/psa/prior-authorization-toolkit_0.pdf. Accessed May 20, 2019.

⁵ American Medical Association. 2016 AMA Prior Authorization Physician Survey. 2016. <https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/government/advocacy/2016-pa-survey-results.pdf>. Published 2017. Accessed July 25, 2019.

⁶ Jacobson G, Neuman T. Prior Authorization in Medicare Advantage Plans: How Often Is It Used? The Henry J. Kaiser Family Foundation. <https://www.kff.org/medicare/issue-brief/prior-authorization-in-medicare-advantage-plans-how-often-is-it-used/>. Published October 24, 2018. Accessed June 9, 2019.

⁷ Kaiser Family Foundation, Kaiser State Facts, States Reporting Managed Care Pharmacy Uniform Preferred Drug List (PDL) Requirements.

⁸ United States Government Accountability Office. CMS Should Take Actions to Continue Prior Authorization Efforts to Reduce Spending. <https://www.gao.gov/assets/700/692138.pdf>. Published: Apr 20, 2018. Publicly Released: May 21, 2018.

⁹ Medicare Payment Advisory Commission. Report to the Congress: Medicare and the health care delivery system. June 2018

¹⁰ Hendel R. Utilization Management of Cardiovascular Imaging: Pre-Certification and Appropriateness. *JACC: Cardiovascular Imaging*. Volume 1, Issue 2, March 2008, Pages 241-248.

¹¹ Lu C, Adams A, Ross-Degnan D, Zhang F, Zhang Y, Salzman C and S Soumerai. Association Between Prior Authorization for Psychiatric Medications and Use of Health Services Among Medicaid Patients with Bipolar Disorder. *Psychiatric Serv*. 2011 February; 62(2): 186–193.

¹² Rajagopalan, 2016 (11 of 15 studies summarized related to prior authorization policies)

¹³ Cochran G et al. Medicaid Prior Authorization and Opioid Medication Abuse and Overdose. *AJMC*. <https://www.ajmc.com/journals/issue/2017/2017-vol23-n5/medicaid-prior-authorization-and-opioid-medication-abuse-and-overdose/>. Accessed June 11, 2019.

¹⁴ American Medical Association. 2018 AMA Prior Authorization Physician Survey. 2018. <https://www.ama-assn.org/system/files/2019-02/prior-auth-2018.pdf>. Published 2019. Accessed July 25, 2019.

¹⁵ Asher A et al. First Interim Evaluation Report of the Medicare Prior Authorization Model for Repetitive Scheduled Non-Emergent Ambulance Transport (RSNAT). Mathematica Policy Research. HHSM-500-2014-00034 February 2018.

¹⁶ Asher A, Coopersmith J, Haile G, and T Chen. Evaluation of the Medicare Prior Authorization Model for Non-Emergent Hyperbaric Oxygen (HBO): Final Report. Mathematica Policy Research. HHSM-500-2014-00034. May 2019.

¹⁷ United States Government Accountability Office. CMS Should Take Actions to Continue Prior



Authorization Efforts to Reduce Spending. <https://www.gao.gov/assets/700/692138.pdf>. Published: Apr 20, 2018. Publicly Released: May 21, 2018.

¹⁸ Goodman RM, Powell CC, Park P. The Impact of Commercial Health Plan Prior Authorization Programs on the Utilization of Services for Low Back Pain. *Spine*.

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4834807/>. Published May 2016. Accessed July 30, 2019.

¹⁹ American Medical Association. 2018 AMA Prior Authorization Physician Survey. 2018. <https://www.ama-assn.org/system/files/2019-02/prior-auth-2018.pdf>. Published 2019. Accessed July 25, 2019.

²⁰ Casalino LP, Nicholson S, Gans DN, et al. What does it cost physician practices to interact with health insurance plans? *Health Affairs (Millwood)*. 2009;28:w533–43.

²¹ Morley CP, Badolato DJ, Hickner J, Epling JW. The impact of prior authorization requirements on primary care physicians' offices: report of two parallel network studies. *J Am Board Fam Med*. 2013; 26:93-95.

²² American Medical Association. 2018 AMA Prior Authorization Physician Survey. 2018. <https://www.ama-assn.org/system/files/2019-02/prior-auth-2018.pdf>. Published 2019. Accessed July 25, 2019.

²³ Bergeson JG, Worley K, Louder A, Ward M, Graham J. Retrospective database analysis of the impact of prior authorization for type 2 diabetes medications on health care costs in a Medicare Advantage Prescription Drug Plan population. *Journal of Managed Care Pharmacy*.

<https://www.ncbi.nlm.nih.gov/pubmed/23697475>. Published June 2013. Accessed July 30, 2019. Published June 2013.

²⁴ Walthour A, Seymour L, Tackett R, Perri M. Assessment of Changes in Utilization of Health-Care Services after Implementation of a Prior Authorization Policy for Atypical Antipsychotic Agents. *Annals of Pharmacotherapy*. 2010 May;44(5):809-18.

²⁵ Zhang Y, Adams AS, Ross-Degnan D, Zhang F, Soumerai SB Effects of prior authorization on medication discontinuation among Medicaid beneficiaries with bipolar disorder. *Psychiatr Serv*. 2009 Apr;60(4):520-7.

²⁶ American Hospital Association et al. Consensus Statement on Improving the Prior Authorization Process. <https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc-public/prior-authorization-consensus-statement.pdf>. Published January 17, 2018. Accessed July 21, 2019.

²⁷ Kaiser Family Foundation State Health Facts, “States Reporting Managed Care Pharmacy Uniform Preferred Drug List (PDL) Requirements.” Source: Kaiser Family Foundation Survey of Medicaid Officials in 50 states and DC conducted by Health Management Associates, October 2018.

<https://www.kff.org/medicaid/state-indicator/states-reporting-managed-care-pharmacy-uniform-preferred-drug-list-pdl-requirements/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> Accessed July 30, 2019.

²⁸ Covermymeds' 2019 ePA National Adoption Scorecard

²⁹ Berry K. “Prior Authorization.” Presentation to Health Information Technology Advisory Committee Office of the National Coordinator for Health Information Technology. March 2019.

https://www.healthit.gov/sites/default/files/facas/2019-03-20_Public_and_Private_Payer_Perspective_AHIP_Kate_Berry.pdf

³⁰ https://www.aha.org/system/files/hpoe/MHA_Case_Studies/AMedicationPriorAuthorizationPilotProgramInPrimaryCarePracticesIncreasesEfficiencyandPatientCareOutcomes_MHA.pdf

³¹ Cutler T, Yifan S, Barca J, Lester S, Xing G, Patel J and J Melnikow. Impact of Pharmacy Intervention on Prior Authorization Success and Efficiency at a University Medical Center. *J Manag Care Spec Pharm*. 2016;22(10):1167-71

³² Morris ZS, Wooding S, Grant J. The answer is 17 years, what is the question: understanding time lags in translational research. *J R Soc Med*. 2011; 104:510-20.

<https://journals.sagepub.com/doi/10.1258/jrsm.2011.110180>