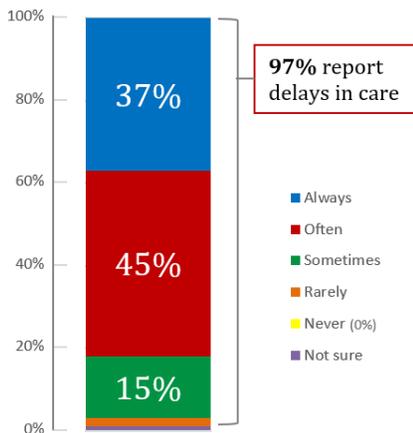


Prior Authorization is Putting Patients at Risk and Increasing Physician Burden

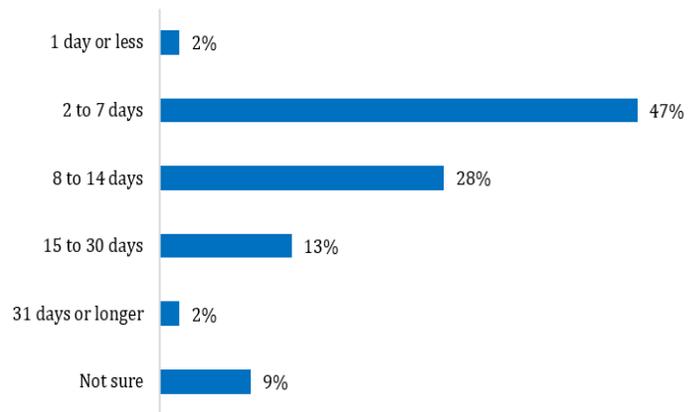
Patient Access to Care Has Been Adversely Impacted

Nearly all respondents state that prior authorization causes **delays in access** to necessary care, and the **wait time** for prior authorization can be lengthy. For most physicians (74%) it takes between 2 to 14 days to obtain prior authorization, but for 15%, this process can take from 15 to more than 31 days.

Q. For those patients whose treatment requires prior authorization, how often does this process delay access to necessary care?

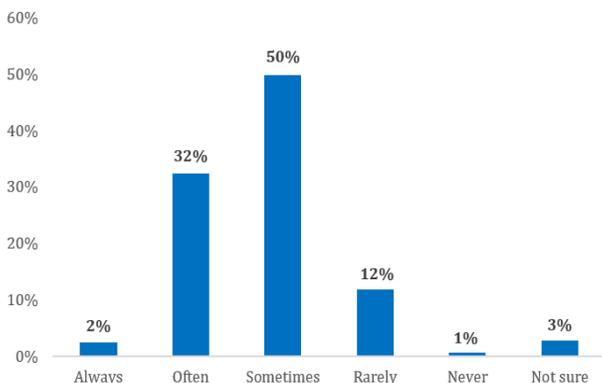


Q. What is the average length of time to obtain prior authorization after all required documentation has been submitted?

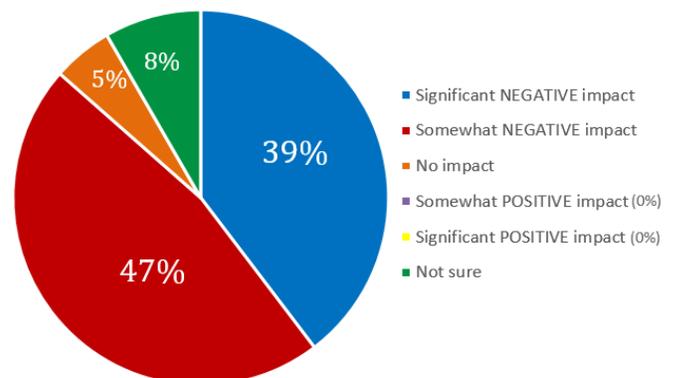


A majority of physicians reported that prior authorization causes patients to **abandon treatment** altogether. Similarly, three-quarters (74%) of respondents reported that during the past five years, stable patients had been asked to **switch medications** by the health plan even though there was no medical reason to do so. Overwhelmingly (87%), physicians report that prior authorization has a **negative impact** on patient **clinical outcomes**.

Q. For those patients whose treatment requires prior authorization, how often do issues related to this process lead to patients abandoning their recommended course of treatment?



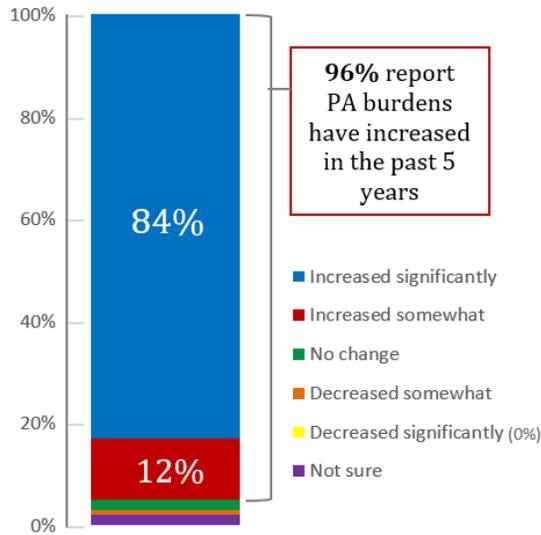
Q. For those patients whose treatment requires prior authorization, what is the impact of this process on patient clinical outcomes?



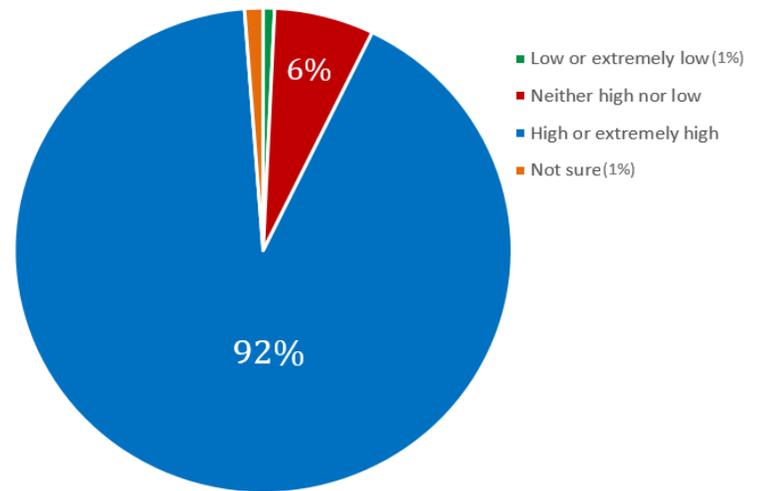
The Burden of Prior Authorization on Physicians Has Increased

Most physicians (84%) report that the **burden** associated with prior authorization has **significantly increased** over the past five years as insurers have increased the use of prior authorization for procedures (84%); for diagnostic tools (78%); and for prescription medications (80%). The burden associated with prior authorization for physicians and their staff is now **high** or **extremely high** (92%).

Q. How has the burden associated with prior authorization changed over the last five years for the physicians and staff in your practice?

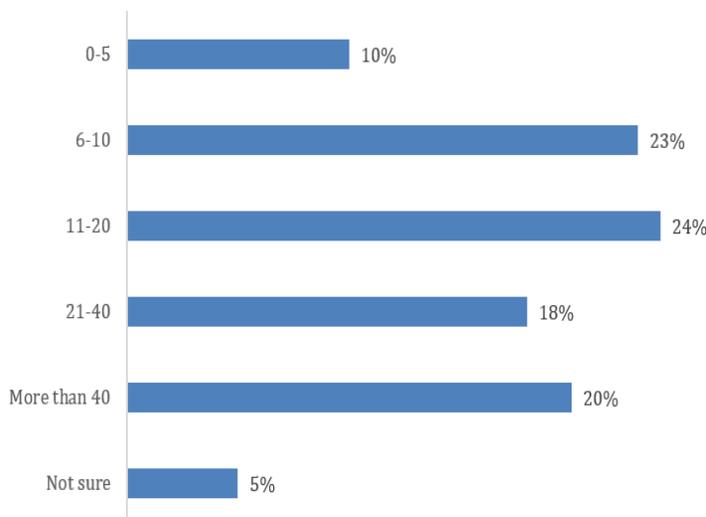


Q. How would you describe the burden associated with prior authorization for the physicians and staff in your practice?



In any given week, most physicians (42%) must contend with between 11 and 40 prior authorizations. One-fifth of respondents face more than 40 per week. Many physicians must now engage in the so-called **peer-to-peer** process — meaning after they go through an extensive paperwork process they must first speak directly to a clinician working for the health plan— to obtain prior authorization, and nearly 20% of respondents experience this requirement for 26-75% or more of their services (including prescription drugs, diagnostic tests and medical services).

Q. Please provide your best estimate of the number of prior authorizations (total for prescription medicine, diagnostic tests and medical services) completed by yourself and/or your staff for your patients in the last week.



20% of physicians go to “peer-to-peer” review for **26-75%** or more of their prior authorizations—and frequently the reviewer is not in the same or similar specialty



Ultimately, the **majority of services are approved** (71%), with one-third of physicians getting approved 90% or more of the time. Unbelievably, despite gaining prior authorization, insurance companies **deny payment after services are rendered**, an outcome three-fifths of physicians have experienced more than once in the past year, and 16% have had this happen 20 or more times.

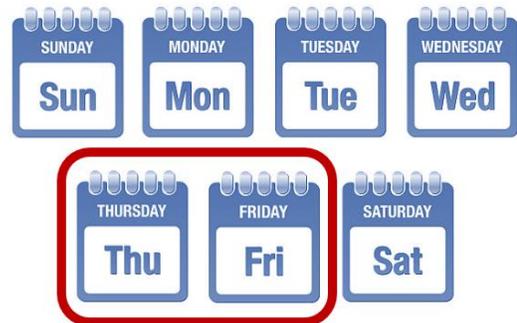
Prior Authorization has a significant impact on the **costs of practice**

59%



Nearly three-fifths of physicians have staff members **working exclusively** on prior authorization

Physicians and their staff spend the equivalent of at least **two days** on prior authorization each week.



Survey Methodology

A 27-question, web-based survey was administered from November 2018 through January 2019. Survey invitations were sent to physicians via email. 1,602 physicians from the following medical specialties participated: Dermatology, Neurosurgery, Obstetrics & Gynecology, Ophthalmology, Orthopaedic Surgery, Otolaryngology, Plastic Surgery and Urology.

Forty-one percent of respondents are from the South; 19% from the Northeast; 24% from the Midwest; and 16% from the West and U.S. Territories. Nearly one-third (60%) of respondents are in private practice; 9% are in private practice with an academic affiliation; 17% are in academic practice; and 12% are employed by a hospital or health system. Twenty percent of respondents are in solo practice; 29% are in a small group (2-5 physicians) single specialty practice; 22% are in a medium (6-20 physicians) group single specialty practice; 9% are in a large group (21+) single specialty practice; and the remainder are in multi-specialty group practices. Forty-five percent of respondents practice in an urban setting; 44% practicing in a suburban setting; while only 11% are in rural practice.

About the Regulatory Relief Coalition

The Regulatory Relief Coalition is a group of eight national physician specialty organizations advocating for a reduction in Medicare program regulatory burdens to protect patients' timely access to care and allow physicians to spend more time with their patients. Members include: American Academy of Neurology, American Academy of Ophthalmology, American Association of Neurological Surgeons, American College of Cardiology, American College of Rheumatology, American College of Surgeons, American Urological Association, and Congress of Neurological Surgeons.

More Information

For more information about the Regulatory Relief Coalition's prior authorization survey, please contact:

Katie O. Orrico, Director
Washington Office
American Association of Neurological Surgeons/
Congress of Neurological Surgeons
25 Massachusetts Avenue, NW, Suite 610
Washington, DC 20001
Direct: 202-446-2024
Email: korrnico@neurosurgery.org