

# Questions to ask health plans during benefit contracting season

*Benefit plans with excessive prior authorization (PA) requirements can block access to care that you and your employees have already paid for via subsidies and premiums. Moreover, plans with overly restrictive benefit designs are not in employees' best interest due to the associated care delays and negative health outcomes.*

***To understand how coverage restrictions, such as PA, may impact your employees, consider asking the following questions during the next benefit contracting season:***

- **What are the health plan's PA requirements, and how can this information be accessed by employees and their physicians?**
- **Does the plan use benefit managers?**  
Insurers often outsource PA processing to third parties, which can complicate communication.
- **What is the basis for the plan's PA requirements, and how does the plan decide to add/remove a service from the PA list?**  
Insurers' PA requirements should be based on accurate, current clinical criteria and never cost alone. In addition, plans should judiciously apply PA to just those services with significant variation in utilization patterns. Services/drugs with high PA approval rates should be removed from the plan's PA list.
- **Who reviews PA requests?**  
Insurer reviewers should have appropriate clinical expertise (i.e., be of the same specialty/subspecialty as the requesting physician).
- **What percentage of drugs/medical services require PA?**  
If a large percentage of employees have certain needs (e.g., high incidence of rheumatoid arthritis), ask more questions about disease-specific coverage.
- **What is the plan's average turn-around time for PA processing?**  
This will indicate if employees are likely to go without treatment for an extended period of time.
- **What is the denial rate of PA requests under the plan?**  
When a PA is denied, the employee cannot receive the prescribed treatment unless they pay out of pocket or fight the denial via an appeal.
- **What percentage of denied PAs are ultimately approved?**  
A high rate of denials overturned on appeal suggests that a plan's PA criteria are clinically inappropriate and/or excessive.
- **How often does the health plan change PA requirements?**  
A change in PA requirements mid-year means that employees may face abrupt disruptions in treatment, which can be especially problematic for chronic conditions. Care interruptions are stressful and time-consuming for employees.
- **Do treatments for life-long/chronic conditions (e.g., insulin for type 1 diabetes) have PA requirements? If so, what is the volume of these requirements? Does the plan offer exemptions/waivers of PAs for patients on long-term treatment for chronic diseases?**  
Employees with chronic illnesses should not have to repeatedly jump through hoops and/or face care disruptions to receive treatment that they've successfully used for years.
- **Does the plan require step therapy or impose "fail first" requirements on any treatments?**  
Under a step therapy program, a patient must first try and fail an inexpensive treatment before being eligible to receive the therapy ordered by their physician. If employees are required to try inexpensive but less effective treatments first, their health may decline—leading to increased overall costs and reduced productivity.

***Learn more about the effects of prior authorization at [FixPriorAuth.org](https://www.fixpriorauth.org)***