Big step forward in Congress to fix prior authorization

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Kevin B. O'Reilly
News Editor
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What’s the news: The powerful House Ways and Means Committee has advanced provisions that would help bring badly needed reforms to the prior-authorization process within Medicare Advantage.

The provisions passed last week hew closely to the Improving Seniors’ Timely Access to Care Act. That bipartisan legislation was introduced by Reps. Suzan DelBene, D-Wash., Mike Kelly, R-Pa., Ami Bera, MD, D-Calif., and Larry Bucshon, MD, R-Ind. The bill's provisions are strongly supported by the AMA, which played a major role in securing enough cosponsors to ensure it passed the House of Representatives (PDF) last September. The legislation, however, stalled in the Senate due to a flawed $16 billion cost estimate from the Congressional Budget Office (CBO).

Among other critical steps, the Ways and Means-passed provisions would:

- Require Medicare Advantage plans—through which over 30 million older adult Americans get care—to implement electronic prior-authorization programs that adhere to new federal standards, as well as establish real-time decision-making processes for items and services that are routinely approved.
- Enhance transparency by requiring Medicare Advantage plans to report to the Department of Health and Human Services (HHS) on the extent of their use of prior authorization and the rate of approvals and denials.
- Require plans to adopt transparent prior-authorization programs that disclose to physicians and beneficiaries the services requiring approval and the underlying policies and criteria.
- Permit Medicare Advantage plans to institute gold-carding provisions.
- Mandate that Medicare Advantage plans issue accelerated prior authorization decisions for all services in Medicare Part C.

The House Ways and Means Committee passage comes on the heels of a bipartisan, bicameral letter to HHS and the Centers for Medicare & Medicaid Services (CMS) urging CMS to finalize a pending federal regulation that would overhaul prior-authorization requirements within Medicare Advantage.
Ultimately, 61 Senators cosigned the letter, along with 233 House members. The AMA helped spearhead support for the letter, and the AMA’s Physicians Grassroots Network and Patients Action Network worked to ensure a robust number of members of Congress cosigned this important communication to CMS.

The Biden administration’s pending prior-authorization regulation provides a key pathway for overcoming the high price tag associated with enacting the legislation’s provisions. If the final prior-authorization regulation includes a mechanism for issuing real-time decisions, requirements to complete urgent requests within 24 hours, and detailed transparency metrics, then these policies must in turn be incorporated into CBO’s baseline estimate for the legislation.

That could mean a big drop in the agency’s $16 billion cost estimate for the legislation, thus upping the odds of congressional passage.

Fixing prior authorization is a critical component of the AMA Recovery Plan for America’s Physicians.

Prior authorization is overused, and existing processes present significant administrative and clinical concerns. Find out how the AMA is tackling prior authorization with research, practice resources and reform resources.

**Why it’s important:** While payers claim that prior-authorization requirements are used for cost and quality control, a vast majority of physicians report that the protocols lead to unnecessary waste and avoidable patient harm. One-third of the 1,001 physicians surveyed (PDF) by the AMA in December reported that prior authorization has led to a serious adverse event for a patient in their care.

More specifically, the AMA survey found that these shares of the physician respondents reported that prior authorization led to:

- A patient’s hospitalization—25%.
- A life-threatening event or one that required intervention to prevent permanent impairment or damage—19%.
- A patient’s disability or permanent bodily damage, congenital anomaly or birth defect, or death—9%.

“The unfortunate reality is that prior authorization is overused, costly, inefficient, opaque and responsible for patient care delays and denials that often lead to poor health care outcomes,” said AMA President Jesse M. Ehrenfeld, MD, MPH.


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“Patients and physicians are grateful that the Ways and Means Committee has displayed focus and tenacity in pursuing this legislation. The AMA looks forward to working in a bipartisan manner with lawmakers to ensure the Improving Seniors’ Timely Access to Care Act is ultimately enacted before the end of the 118th Congress,” Dr. Ehrenfeld said.

Learn more: The AMA also recently urged (PDF) CMS not to increase prior-authorization requirements within the traditional Medicare fee-for-service program, strongly objecting to policy changes that would negatively affect Medicare patients and their physicians.

Patients, physicians and employers can learn more about reform efforts and share personal experiences with prior authorization at FixPriorAuth.org.

Visit AMA Advocacy in Action to find out what’s at stake in fixing prior authorization and other advocacy priorities the AMA is actively working on.