



Time to crack down on ERISA plans' use of prior authorization



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The AMA has had success advocating improvements to the prior authorization process in state-regulated plans, as well as in health plans regulated by the Department of Health and Human Services (HHS) such as Medicare Advantage, Medicaid and Medicaid managed-care plans.

Now the AMA is taking a unique opportunity to advocate that prior authorization reforms take root, for the first time, in employer-sponsored health plans.

The AMA provided written and oral testimony (PDF) to an advisory council tasked with giving the Department of Labor recommendations on possible regulatory changes to improve how employer-sponsored health plans regulated under the Employee Retirement Income Security Act of 1974 (ERISA) can use prior authorization and manage their claims and appeals procedures.

“The AMA considers the work of this committee to be timely and important, as overly burdensome and opaque claims and appeals procedures and the use of inappropriate utilization management programs are increasingly harming patients, intruding in the patient-physician decision-making process, and undercutting the stability of physician practices,” the AMA said in its written statement submitted last month to the 2024 ERISA Advisory Council on Employee Welfare Benefit Claims and Appeals Procedures.

The AMA urged the advisory council to recommend changes to the Labor Department’s rules governing prior authorization, claims and appeal processes to reduce harms and burdens imposed on patients and physicians. The AMA told the committee about some of the most pressing issues that AMA members encounter when trying to ensure their patients are covered for the care that is recommended and outlines reforms and recommendations that the advisory council may want to include in its report to the Department of Labor (DOL).

“All patients—including those covered by plans regulated by the DOL—should be protected from draconian health insurer practices that limit access to and payment for clinically appropriate medical services and drugs,” says the AMA’s testimony.



The AMA is fixing prior authorization by challenging insurance companies to eliminate care delays, patient harms and practice hassles.

Detailing prior authorization's impact

To lay out the problem, the AMA statement details that physicians and other health professionals find prior authorization “programs to be time-consuming barriers to the delivery of necessary treatment.” And, according to the testimony, the payer cost-control process wastes “significant practice resources, as practices report completing an average of 43 prior authorizations per physician, per week, with this weekly workload consuming 12 hours of physician and staff time—time that is not being spent on patient care as a result.”

Those figures come from the AMA's latest annual survey (PDF) of 1,000 practicing physicians about prior authorization. The survey also found among those physicians:

- 94% reported prior authorization led to delays in patients accessing necessary care.
- 93% reported that prior authorization can negatively impact clinical outcomes.
- 24% reported that prior authorization led to a serious adverse event for the patients, such as hospitalization, disability or even death.

The AMA testimony also cited findings from the American Society for Clinical Oncology and the American Cancer Society Cancer Action Network that showed how prior authorization negatively affected patients' disease progression and even resulted in loss of life. A study from KFF also shows the negative impact prior authorization has on patients.

Further, physicians say that peer-to-peer reviews are typically not with peers who have the same knowledge and training the treating physician does and that they have experienced obviously-needed and covered care declined.

For example, a 2022 Office of Inspector General report found that 13% of prior authorization requests that Medicare Advantage plans denied actually met Medicare coverage rules; 18% of payment request denials met Medicare and Medicare Advantage billing rules. In one example, a 76-year-old with multiple orthopaedic conditions and at risk of falling was denied a walker because the patient received a cane in the past five years.

“These findings call into serious question the validity of the clinical criteria being used by health plans in coverage decisions and suggest a consistent failure among plans to base criteria on nationally recognized standards of care as determined by the appropriate national medical specialty society,” says the AMA statement. And with no transparency in health plans' process, it's extremely difficult for physicians to assess the validity of a denial.



Change employer-sponsored plan rules

The testimony outlines meaningful reforms and changes the advisory committee can recommend to the Labor Department, some of them changes that state-regulated plans and HHS plans have already undertaken.

This includes, for example, reducing delays and requiring faster health plan response times for prior authorizations. The AMA supports a maximum 24-hour response time for urgent requests and 48 hours for nonurgent requests, something federal and state policy has shifted to more closely reflect. The AMA also supports the use of the Fast Healthcare Interoperability Resources standard to allow a physician—within the EHR workflow—to determine whether a service being ordered requires prior authorization, the documentation requirements necessary for approval and whether the request is approved, denied or requires additional information before a determination can be made.

Another prior authorization reform aims to improve patients' continuity of care. For example, the 2024 Medicare Advantage final rule prohibits repeat prior authorizations, especially for patients with chronic conditions. Several states have adopted similar laws.

Among the recommendations in the testimony—including some drawn from the consensus on improving prior authorization (PDF) that the AMA and other national organizations representing health care providers and insurers released nearly seven years ago—are:

- Increasing the clinical integrity of decision-making at the initial and appeal levels.
- Increased transparency of insurer requirements.
- Data transparency, collection and reporting.
- Mental health and substance use disorder parity enforcement.
- Limiting the use of utilization management requirements.

An AMA model bill (PDF) can help physicians get started on advocating change in their own state legislatures. It includes language to establish that only a qualified physician can make an adverse determination on prior authorization.

Patients, physicians and employers can learn more about reform efforts and share their personal experiences with prior authorization at [FixPriorAuth.org](https://www.amapriorauth.org).