Fight to fix prior auth makes headway in Washington

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If you’re seeking to influence federal laws and policies, it helps to have the head of a large federal agency and nearly 200 members of Congress on your side—which is the case with the AMA’s effort to enact prior-authorization reform.

The 500 physicians and medical society executives attending the AMA National Advocacy Conference in Washington visited their legislators and told them that patients are harmed by prior authorization (PA), an insurance company cost-control process by which physicians and other health care providers must obtain advance approval from a health plan before a specific service is delivered to the patient to qualify for payment coverage.

“The prior authorization process became indefensible years ago,” Seema Verma, administrator for the Centers for Medicare & Medicaid Services (CMS), said during a speech at the conference. “Patients are frustrated, and doctors are sick of pointlessly wrangling with insurance companies.”

Verma was applauded when she said that PA reforms would be connected to CMS efforts this year to boost innovation and reduce physicians’ administrative burdens.

“Prior-authorization requirements are a primary driver of physician burnout,” she said. “And, even more importantly, patients are experiencing needless delays in care that are negatively impacting the quality of care.”

Learn more from the AMA about eight prior authorization terms that drive every doctor crazy.

How prior auth leads to hospitalizations

During a panel discussion with AMA leaders, AMA President-elect Susan R. Bailey, MD, cited an AMA survey of 1,000 practicing physicians in which 16% of respondents said they had a patient who ended up in the hospital due to PA-related delays.
She recommended that physician advocates highlight the “striking” figure when visiting their legislators. Beyond statistics, however, Dr. Bailey urged physicians to tell their senators and representatives stories of how PA has had an adverse impact on patients.

“Stories are what legislators remember,” she said.

Dr. Bailey, an allergist/immunologist from Fort Worth, Texas, recalled filling a PA request for a generic medication that a baby needed. The insurance company would only authorize a chewable form of the medication—even though the infant hadn’t started teething yet.

“Patients are not able to get their medications,” she said. “Their treatment plan is disrupted, and a big chunk of patients are ending up in the hospital.”

The fight over PA reform has largely been waged at the state level. But the CMS “Patients Over Paperwork” initiative and a federal bill to reform the PA process for Medicare Advantage (MA) plans is putting a new focus on Washington. Discover how CMS can fix prior auth to put patients before paperwork.


The AMA was one of 400 physician and health care-related organizations that signed a letter to members of Congress urging them to co-sponsor the bill. The letter notes that 22 million Medicare beneficiaries belong to MA plans—of which, 79% require PA for some services.

The AMA has also produced a video explaining why the bill should be supported.
Rep. Suzan DelBene, D, Wash., spoke to physicians about her bill to reform prior authorization in Medicare Advantage plans. The bill is sponsored by Rep. Suzan DelBene, D, Wash., who spoke at the conference and noted that her bill’s provisions stem from the consensus statement on improving PA that was developed by the AMA, other health care professional associations and payer trade organizations.

These provisions include:

- Requiring electronic prior authorization. “That would mean no more phone calls and no more faxes,” DelBene said as attendees applauded.
- Standardizing PA so every insurer uses the same electronic process.
- Allowing the Health and Human Services secretary to require real-time decisions for routine, noncomplex services that have high approval rates to encourage payers to forgo PA for services that don’t need it.
- Creating a surgical exception so, during surgery, if a physician furnishes an additional service that is in the patient’s best interest to immediately address, he or she can do so without needing an additional PA.
- Requiring transparency. This includes payers listing all services that require PA, disclosing what information is needed to complete a request, and reporting their rate of approvals, denials, successful appeals and time it takes to complete requests.

“That information will be very helpful for us to understand what works, what doesn’t work and make sure we continue to address outstanding issues going forward,” DelBene said.

DelBene added that she’s heard from physicians and others in her district and across the country that the PA process seems to be “deliberately burdensome and time-consuming.”

**PA runs contrary to medical training**

One of the bill’s co-sponsors, Rep. Andy Harris, MD, R, Md., also spoke at the AMA National Advocacy Conference, and he noted that PA and step therapy, often called “fail-first protocols,” run contrary to physician ethics and training.

“When I went to medical school, we were taught that every patient is different from every other one—every patient is an individual,” said Dr. Harris, an anesthesiologist and AMA member. “I graduated in 1980. Fast forward to 2020: ‘Nope. Every patient’s alike. If you have this diagnosis, this is the best therapy for you.’”