

## Efforts to fix prior auth move ahead in Congress, states

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The AMA and the Michigan State Medical Society (MSMS) are working together to get state and federal legislation passed that would require health insurers to do what they agreed to do two years ago: Streamline the prior-authorization (PA) process so patients can receive the care they need without unwarranted delays.

“Our patients are suffering because insurers, even during a pandemic, are choosing profits over patient care—this must stop,” said AMA President Susan R. Bailey, MD. “Because insurers will not change their ways despite their rhetoric, policymakers have an important opportunity to rein in prior-authorization requirements that adversely affect patient health.”

Michigan otolaryngologist S. Bobby Mukkamala, MD, has watched with growing frustration as patients’ medical conditions worsen due to delays caused by prior authorization.

As an ENT, he saw a patient who wasn’t able to breathe through the left side of his nose due to a significant deviated septum. Dr. Mukkamala could fix the issue and improve the patient’s airflow with a simple procedure, but before he could do that, his office would have to submit documentation to the patient’s insurance company, and then wait days or weeks to get confirmation that the procedure could be performed.

That example is not life-threatening. Others are.

A different patient had cancer in the tonsil that needed radiation therapy. To evaluate the stage of cancer, an order was placed, and the insurance paperwork was filed for a PET scan. Three weeks later, the insurance company approved the procedure. In that time, the patient developed a lump in the neck as the cancer spread, forcing the patient to need chemotherapy on top of radiation.

“We’re seeing people suffer more while we’re waiting days or weeks to do what we know needs to be done,” said Dr. Mukkamala, MSMS president and chair-elect of the AMA Board of Trustees. “It affects our morale and how we practice, and it frustrates our patients.”

Discover more stories of how prior authorization affects patients and physicians at the AMA's FixPriorAuth.org website.

## Legislation clearly needed

PA is a health plan utilization-management or cost-control process that requires physicians to obtain approval before a prescribed treatment, test or medical service qualifies for payment. The AMA offers prior-authorization resources to support reform, improve practice efficiency and provide data to highlight the need for change.

Armed with survey data and personal stories from patients, the AMA and MSMS have been pressing national and state lawmakers to pass reforms.

On the federal level, they are urging Congress to pass HR 3107, a bill that would streamline and standardize PA and improve transparency in Medicare Advantage plans. A bipartisan group of 234 members of the U.S. House of Representatives have co-sponsored the bill.

In Michigan, the MSMS has joined with the Health Can't Wait Coalition, and has supported SB 612, state legislation that introduces transparency and clinical validity requirements to ensure patients have access to care.

"MSMS and the AMA call on Michigan lawmakers to take action in the coming legislative session on behalf of patients and enact S.B. 612," Dr. Mukkamala said. "Now is the time to make sure that insurers are not standing in the way of patients' access to covered services, deterring patients from seeking care, or intruding in the patient-physicians relationship."

## Bills based on agreed-upon reforms

The federal and state bills incorporate several provisions included in a consensus statement on improving prior authorization that was developed by the AMA, other health care professional associations and payer trade organizations.

The statement, released in 2018, identified opportunities for improving the PA process and had detailed agreements to take specific actions. These included:

- | Selective application of PA based on measures such as provider adherence to evidence-based medicine.
- | Regular review of requirements to eliminate PA for services, drugs and therapies that no

- longer warrant PA due to low variation in utilization or low denial rates.
- Improved transparency to clearly articulate the criteria and rationale for when PA is required.
- Automation to improve transparency of PA requirements and efficiency of PA processes.
- Protections for continuity of care when patients change plans or insurers change benefit design.

## Physicians say burden keeps growing

Nearly a quarter of physicians (24%) say that the PA process has led to a serious adverse event for a patient in their care, according to an AMA survey of 1,000 practicing physicians. Overwhelming majorities said PA has delayed access to necessary care, negatively affected clinical outcomes, and led patients to abandon their recommended course of treatment.

Similarly disturbing results were found in a survey of doctors in Michigan:

- 94% reported that PA causes delays in care for their patients.
- 73% reported that PA requirements force patients to wait at least one business day before getting the treatment they need.
- 38% reported that PA forces patients to wait three or more days before getting needed medicine or treatment.
- 97.5% of PA requests are eventually approved, meaning insurers delay patient care for no reason.

Dr. Mukkamala is optimistic and hopes other states without laws in place follow the lead of Michigan and other states that have already enacted PA reforms.

“The more state capitols that are looking at bills like ours, the better,” he said. “The more states that start to push for this sort of revision of the laws to make prior authorization right-sized, the better it will help all of us collectively.”