

# Time for employers to grill their health plans on prior authorization

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Health insurance companies like to tout their prior authorization process as a cost-saving measure. The AMA, however, is telling employers that prior authorization is nothing of the sort—and can actually drive up costs and lead to employee absenteeism.

“Prior authorization may not be a bargain for you or your employees,” declares the opening page of the employer track on the AMA’s [FixPriorAuth.org](https://www.ama-assn.org/fixpriorauth) grassroots advocacy website.

The site includes information on the impact of prior authorization on patients in terms of cost and delays in receiving care that can lead to employee absenteeism and abandonment of treatment.

Prior authorization is a health plan utilization-management or cost-control process that requires physicians to get approval before a prescribed treatment, test or medical service qualifies for payment. Prior authorization poses significant administrative burdens for practices and delays patients from receiving necessary care.

## Key questions for employers to ask

Resources include a document (PDF) that provides employers with information on how delays in care caused by prior authorization can lead to employee absenteeism. It also contains case studies illustrating the negative impact of common prior authorization delays and the results of a December 2020 survey of 1,000 practicing physicians that details the harms caused by prior authorization.

There is also a new one-page “Questions to ask health plans during benefit contracting season” (PDF) resource.

The questions help employers—the nation’s largest purchasers of health insurance—to choose the right company to provide coverage for their workforce. The resource also explains what a company’s answers mean.

Employers, for example are encouraged to ask for a plan’s average turn-around time for prior authorization processing. The answer will give an indication of whether employees will go without treatment for an extended time.

Employers also should ask health plans what percentage of denied prior authorizations are ultimately approved. A high rate of overturned denials suggests that a plan’s prior authorization criteria are clinically inappropriate or excessive.

If a health plan changes its prior authorization requirements in the middle of the year, employees may be facing disruptions in treatment which can be especially problematic for those with chronic conditions.

Similarly, plans need to be asked about any prior authorization requirements they have for employees who have been successfully managing their chronic condition over long periods using the same medication.

“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,” the resource says.

## Taking it up with HR

AMA advocacy efforts extend beyond the website. AMA representatives will also be attending the Society of Human Resources Management (SHRM) annual conference being held virtually and in person this September in Las Vegas. AMA staffers will be hosting a booth to distribute prior authorization materials and will be presenting a sponsored lecture.

It is the first time the AMA will be appearing at the event, and representatives will be speaking directly to the thousands of human resource and benefit management professionals from major companies in attendance.

Employers face challenges in providing health care benefits that offer access to quality care while also managing costs and bargaining benefit contracts. Employers need to also know that “excessive” prior authorization requirements “are not in employees’ best interest due to the associated care delays and negative health outcomes,” the FixPriorAuth.org site says.

In a video on the website, AMA President-elect Jack Resneck Jr., MD, talks about patients missing work because they have to wait for their health plan to authorize the generic treatment he prescribed.

AMA member Daniel P. Edney, MD, an internist in Vicksburg, Mississippi, tells of patients driving two hours to see him only to face delays caused by insurers putting up barriers to completing the test he orders. When the test is ultimately approved, Dr. Edney says, “it’s very typical that they won’t come back.”

## **Employers urged to make things happen**

Colin Edgerton, MD, a rheumatologist practicing in North Charleston, South Carolina, urges companies to get involved, saying that, after a company calls their health insurance plan, “that can actually make things happen.”

To that end, the website encourages employers to “learn more and speak up.”

“You do your best to provide employees with an affordable benefit package that ensures access to medically necessary care,” the website notes. “What is the value of health care benefits if your employees can’t receive timely care—or are forced to pay for treatments out of pocket?”