I’m used to my patients’ prior auth hassles. Then came Mom’s.

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As a family physician, the best part of my job is caring for my patients and serving as their partner in a lifelong quest for wellness. Their well-being means everything to me, and I am humbled that they have placed their trust in me.

But as we all know, physicians today face an onslaught of administrative hassles that steal our time with our patients as well as our families. These burdens are major sources of frustration and burnout, especially when they hinder delivery of the best patient care we can provide.

My firsthand experience with pharmacy-related prior authorization illustrates the time-consuming and potentially dangerous nature of this aspect of utilization management. My mom, who will turn 92 this year, takes several generic medications each day and has remained stable while doing so for nearly a decade. But an updated benefit plan that took effect in January imposed wholly unexpected prior-authorization requirements that threatened to deprive her of these vitally important medications for an uncertain length of time.

As a result, I spent nearly an hour on the phone with my mom’s pharmacist, a pharmacy benefit manager, and a service representative from her health plan provider trying to untie this unnecessary knot—to no avail. I then contacted my mom’s physician and her pharmacy provider, who shared their willingness to complete the prior authorization process but noted that it might take a few hours or even a few days to resolve the matter.

I felt helpless, and worried that my mom’s health was being risked unnecessarily—just as countless others have felt when encountering this situation.

The burden of prior authorization
My experience is anything but unique, as anyone who has visited the AMA’s grassroots advocacy site FixPriorAuth.org can tell you. There you can see for yourself the physical and mental toll that prior authorization requirements for prescriptions, procedures, courses of treatment and other vital aspects of health care has taken on patients and their families, physicians, other health professionals, and employers.

The site also invites you to share your own story and add your name to our petition asking Congress to demand that insurance providers work with physicians by streamlining the prior-authorization process and ensuring patients receive timely access to needed care.

It is beyond frustrating to realize that the prior-authorization problem continues to inflict so much harm on so many people. An AMA survey conducted in December found that 93% of physicians said that prior authorization had delayed access to care their patients needed—and 82% said the process had led patients to abandon treatment. More than nine in 10 physicians surveyed said prior authorization negatively affected patient clinical outcomes.

Failure to administer medically necessary care also leads to poor health care outcomes. Most startlingly, 34% of December AMA survey respondents reported that prior authorization led to a serious adverse event, such as hospitalization, disability and permanent bodily damage, or death, for a patient in their care.

Excessive prior-authorization controls hurt employers as well, even as health insurance providers market this utilization management survey as way to control costs. Instead, AMA survey results point to higher costs as a result of lost productivity and greater absenteeism when employees suffer the consequences of delayed, denied or abandoned care.

**Fixing the problem**

We can correct this situation. One prominent federal legislative solution is the Improving Seniors’ Timely Access to Care Act of 2021 (H.R. 3173/S.3018), a bipartisan measure now pending before the U.S. House and Senate that would streamline, standardize and simplify prior authorization under the Medicare Advantage program.

The bill has generated tremendous support, with more than 270 bipartisan sponsors in the House and 18 in the Senate. Enactment of these changes within Medicare Advantage is intended to prompt other health plans to make similar reforms in the commercial market.

Another pathway toward needed reform would be greater compliance with the 2018 Consensus Statement on Improving the Prior Authorization Process (PDF), in which physicians, health plans and
others jointly committed to:

- Selective application of prior authorization.
- Regular reviews of prior-authorization program requirements.
- Improved transparency and communication between participants.
- Continuity of care protection.
- Greater adoption of electronic prior auth transactions.

These desired reforms are also reflected in the Improving Seniors’ Timely Access to Care Act.

Also, our AMA continues to partner with state medical societies and medical specialty organizations to achieve prior authorization and step therapy reforms at the state level. I am pleased to report that major improvements that were based on our own prior authorization model legislation were enacted in both Georgia and Illinois last year, and I am optimistic that similar reform legislation pending in multiple states will become law in 2022.

I should also note that Texas has created gold-carding programs for physicians who reach a specified level of approvals from health plans by consistently ordering or prescribing treatments and drugs in accordance with evidence-based guidelines. Such volume-reduction efforts are included in the AMA’s Prior Authorization and Utilization Management Reform Principles, which have been endorsed by more than 100 organizations.

Overly burdensome prior auth programs have remained a thorn in our collective sides for far too long. I urge you to join our efforts to bring an end to the damage they continue to inflict upon all of us.