AMA Advocacy Insights webinar series: How prior authorization disrupts patient care

Featured topic and speakers

94% of physicians surveyed by the AMA in 2022 said that prior authorization delays access to necessary care, and even worse, 33% of physicians reported that prior authorization has led to a serious adverse event for a patient in their care. Physicians know they spend an inordinate amount of time dealing with the hassles of prior authorization, but when patients are being harmed because of it—it’s clear something has to change.

AMA President Jack Resneck Jr., MD, hosts a webinar to dig further into the current state of prior authorization and how the AMA is working to fix it. Heather McComas, PharmD, director, Administrative Simplification Initiatives, AMA, and Emily Carroll, JD, senior legislative attorney, Advocacy Resource Center, AMA, join Dr. Resneck to talk about the latest reform efforts and how you can get involved. You’ll also hear about results of the AMA’s latest prior authorization survey conducted at the end of 2022.

Host

- Jack Resneck Jr., MD, president, AMA

Speakers

- Heather McComas, PharmD, director, Administrative Simplification Initiatives, AMA
- Emily Carroll, JD, senior legislative attorney, Advocacy Resource Center, AMA

Transcript

Dr. Resneck: Welcome and thank you all for joining today’s webinar. I’m Jack Resneck, president of the American Medical Association. And it is a pleasure to be your host as we dive into an issue that’s a major source of frustration for so many of us, prior authorization. If you’ve ever heard me speak pretty much anywhere, you know that bloated prior auth is a particular pet peeve of mine.
And in today's webinar, which is the latest in our Advocacy Insight series, we're going to examine where prior auth reform efforts are right now, both at the state and federal levels. And we're going to hear from our own AMA experts about the ongoing work of the association and others to rightszie this very onerous process.

And when I travel and meet with physicians around the country, no matter what state I'm in and no matter what specialty they're from, each really has their own prior auth horror stories. In my specialty of dermatology, I knew insurers had really hit a new low when getting approval even for cheap generic cortisone creams that have been widely prescribed since the 1960s began to require several days of faxes and phone calls and appeals before patients could actually pick up their medication and start treatment.

At the same time, more and more of my patients with chronic conditions who had really found successful therapies began to face repeated prior auth hurdles when their health plan just changed formularies or sometimes, frankly, for no reason at all, which repeatedly disrupts their care. When health insurance plans first came up with this process many years ago, we all remember it was primarily for brand new really expensive medications that had just come to market or brand new tests or new procedures.

But it seems each year brings new prior auth demands that lead to care delays, and far too often forced patients to abandon treatments altogether. We actually see that somewhere between a quarter and a third of patients who go to the pharmacy and find out their medication requires prior auth and then we as physicians fight the good fight and get it approved, almost a third of the time, patients don't even show back up to the pharmacy to pick up those medications and start treatment.

So what physicians are experiencing today and what patients are finding when they try to fill prescriptions at their pharmacy is that prior auth is being used for an incredibly broad variety of medications. It's a challenge for physicians, our office staff and, of course, our patients themselves. The fact is the prior authorization process as it currently exists is a burdensome, administrative nightmare.

We physicians often don't at the point of care when we're sitting down in our electronic health records what's going to be on formulary? What's not? What's going to require prior auth? What's going to require step therapy? So our patients first learn that their medication isn't covered typically when they get to the pharmacy and the pharmacist tells them. And so begins that long saga of rejections, ridiculous alternative suggestions from the health plan, appeals sent by fax and ultimately, quote, unquote, "peer to peer calls" with someone at the health plan who's clearly not a peer.

And that's why the AMA has long made reforming the prior authorization process a focal point of our efforts to remove obstacles that interfere with patient care. It's why we generated a grassroots advocacy site, fixpriorauth.org, where thousands upon thousands of physicians and patients so far have already shared their prior authorization experiences to raise awareness to the public, to

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policymakers and to legislators about how it jeopardizes patient health.

I personally use many of those stories when I'm on the hill and in state legislatures. And it's also why we made fixing power where one of the five core pillars of our Recovery Plan for America's Physicians that we introduced last June. The good news is that after years of advocacy on this issue, we're starting to see progress and momentum. It has helped that almost every policy maker I speak with has themselves had a prior auth experience or a family member or a close friend, and they know just how troubling this is.

Just last week, the Center for Medicare and Medicaid Services, CMS, announced that it is taking important steps towards right sizing the prior auth process imposed by Medicare Advantage plans on medical services and procedures. We have, at the AMA, really applauded CMS administrator Brooks-LaSure for leading the effort to include provisions in this final rule to streamline prior auth requirements, to improve clinical validity of coverage criteria and to increase transparency of health plans prior auth process.

Medicare Advantage enrollees will benefit from these important new protections which is going to help reduce disruptions to their care and allow physicians to get back to what we came into medicine for in the first place, treating patients. Additionally, just last year, the U.S. House of Representatives passed in an overwhelming bipartisan way the Improving Seniors Access to Timely Care Act that would have reformed prior auth nationally in the Medicare Advantage program as well.

Unfortunately, it didn't pass in the Senate yet, but new proposed federal regulations address a lot of the same issues covered by the bill and we're going to talk more about those regulations in today's webinar. It's not just at the federal level, we're seeing change happen in states as well.

Recently, there's been a particular emphasis in legislation we're seeing on reducing the growing volume of prior auth, as well as protecting some of the most impacted patients, those with chronic conditions and long term diseases. For example, last year, Texas passed a so-called gold card law which provides a pathway for many doctors to bypass the prior authorization process altogether. It's like TSA pre-check for prior auth.

This year, several states are attempting to do the same and we've seen some states move to prevent repeated prior authorizations as well for patients with chronic conditions so that they don't have to unnecessarily return to their physician's office or have their clinical stability threatened as they wait to get approval for the same treatment for the same condition that they know is already working.

There’s lots more to do, and the AMA is continuing to push to reduce the overall volume of prior authorizations to increase transparency on the requirements, to promote automation and to ensure timely care for our patients. Thanks again for joining us and for being engaged on this important issue. I want to introduce our panelists. So our first panelist is Heather McComas, director of administrative simplification initiatives here at the AMA and one of our foremost experts on prior auth reforms.
Welcome, Heather.

**McComas:** Thanks so much. Great to be here.

**Dr. Resneck:** And our second guest is Emily Carroll. Emily is the senior attorney in the Advocacy Resource Center, our state advocacy group at the AMA and works on growth issues at the state level. Emily, welcome.

**Carroll:** Thanks for having me.

**Dr. Resneck:** Thanks to you both for being here. I have had the pleasure of working with both Heather and Emily for a number of years in various roles at the AMA, and they are real gems that we are lucky to have on our side. So Heather, I'm going to start with you if that's all right. Last month, the AMA released the results of its latest survey on the impact of prior auth. This has been something we've been doing annually for several years so that we can follow trends. Can you tell us about some of the findings related specifically to patient care?

**McComas:** Yeah, sure thing. And as you mentioned, we've been doing this survey annually for the past seven years. And we don't turn the data, but I got to say the results are reliably distressing. This year again, the overwhelming majority of physicians, 94% reported that prior authorization is associated with care delays.

And these care delays aren't just inconveniences, they are annoyances. Our physicians are saying that prior authorization care delays actually hurt patients. 80% of physicians reported that prior authorization can lead to patients completely abandoning a prescribed ordered course of care. 89% of physicians indicated that prior authorization leads to negative clinical outcomes.

And I think most alarming, one third of physicians reported that prior authorization has led to a serious adverse event for a patient in their care. And a serious adverse event is something like hospitalization, permanent impairment or even death. So these are really alarming statistics. And I think the numbers are very helpful to us in our advocacy on this issue.

But I also think, Dr. Resneck, as you were saying that the numbers in combination with the patient stories are what really make an impact on this issue. So I was wondering if you can maybe put a human face behind some of these statistics. Can you give us a couple of examples of how prior authorization has hurt your patient's care?

**Dr. Resneck:** The thing that I have that I've noticed the most really has just been the shocking volume increase as well. We have, at this point in my group, several staff who basically work exclusively on dealing with prior auth. And it's so burns them out that we now actually have to rotate that around the office or else we have people quit because they just can't handle the boring nature of this unnecessary work.
And my daily experience with this is that most of the ones that we're filling out, they're not for big expensive new drugs. It's mostly actually for generics or just things that I prescribe on a daily basis. Oftentimes, things where there's not even a less expensive alternative. I don't know what the heck the health plan actually expects me to do instead. And sometimes it's even just Kafkaesque.

I had a patient I told this story in a hearing a few months ago who had severe head to toe eczema, hadn't slept for months and months. This was an adult. Out of work, really not very present with their family and I ended up putting them on one of the new targeted biologics. And I don't use these for every patient willy nilly. They are expensive. But for this patient, I got it approved. It was life changing, they were back at work, they were productive citizen, their life was transformed really.

And they'd been on the drug for about six months and then the health plan decided to reprior auth one of their refills. So they just show up for a refill and get rejected at the pharmacy. So I dutifully printed out the prior auth form for that health plan, handwrote extensive notes on how much this had changed their life and how well it was working, and faxed it, which is also a ridiculous part of this process.

And it came back rejected, and I was horrified and was trying to figure out the reason for the patient. And the reason it was rejected was that the patient no longer met the severity criteria. Not enough of their body was covered, they were not—they weren't missing enough sleep, they weren't itching enough. I was like, wait a minute. That means the drug is working.

And it took over 20 phone calls to the health plan to fight this. And I was told things like, oh, just take the patient off the medication for several weeks. Let them have a bad flare and then they'll continue again, which is, again, just completely ridiculous. And on, I think, the 22nd or 23rd call, I finally won somebody over and got it overturned, but this is a lot of time that I could have spent with other patients. So it's really gotten ridiculous and out of hand.

And this is, I think, what in every specialty my colleagues on the ground are facing, whether it's procedures or drugs on a daily basis. Heather, I want to come back to you. We often hear health plans that they're using PAs to save on premiums and reduce unnecessary care. They frame it as a bargain. What are some of the overall big picture costs of prior auth in terms of practice burdens, in terms of impact on overall medical and societal cost?

**McComas:** Yeah, sure thing. So obviously, we have the patient harms that you so eloquently talked about. It was a horrifying patient story. But putting that aside for a minute, just the overall societal costs of this process are just ridiculous. And our survey practices reported completing four or five prior authorizations per physician per week.

And that prior authorization workload for a single physician consumed almost two business days of physician and staff time. That is an enormous amount of administrative waste in our health care system. And Dr. Resneck, because you're talking about—because of this, a lot of practices in our survey, 35% reported having staff who just do prior authorization.
I guess you can certainly all feel in our hearts for those folks who do this all day every day. It's really frustrating and a horrible job that requires an unending amount of patients. But certainly, this is consuming a lot of practice resources, but it also is harming other areas of our economy. We included some questions in our survey asking about physicians perspective of this process on patients' ability to work.

And of physicians who have patients in the workforce, over half, 58% indicated that prior authorization has impacted patient job performance, whether it's the fact that the patient had to miss work because they had to schedule an extra visit to the physician because they had an unmet authorization need, or they were too ill to come to work because they couldn't get the care they needed or maybe they came to work, but they weren't productive because they didn't feel well or they were on the phone with their health insurer.

So I think it's really important to think about this aspect of the issue. I know in our advocacy, we are definitely trying to ramp up our messaging to the employer audience. We know that health plans present prior authorization to their employer clients as a way to save money. But I think with these stats, it's clear that really puts that into question. At the end of the day, if your employees are not well enough to come into work and do their job, it's really a big question mark that this process is actually saving employers money at the end of the day.

And then we added a question in this year survey asking physicians perception of the impact of prior authorization on overall health care resource utilization. And the overwhelming number of—overwhelming majority of physicians, 86% indicated that prior authorization can actually increase the overall use of health care resources, which is, again, the polar opposite of what this process is supposed to be doing. Health plans say they're doing it to save money.

Physicians are saying in their experience, prior authorization is actually increasing overall health care cost because patients are being forced to try an ineffective treatment first through things such as DOT therapy. They're having to come in for extra visits or they're ending up in the emergency room and urgent care centers because they weren't able to get the care they need in a timely fashion. So this really raises, I think, some overall existential questions about what we're doing with this process because we know it's hurting patients and it really is increasing costs all over our economy.

Dr. Resneck: Thanks, Heather. One of the questions I saw pop up is whether there's data other than our surveys of physicians that validate our findings? And I just want to say, the answer is a resounding yes. So one of the things that really helped us I think to accelerate the work at CMS was that GAO did a study looking at Medicare Advantage plans.

And not just the volume of prior auth, but they actually talked about the very high percentage of inappropriate prior auth denials that ultimately were overturned. And we've seen this repeated over and over again in the data. The health plans are very tight about limiting transparency of what they're doing on prior auth, but there have been some very clever studies done, including looking at an area
before and after, for example, when a Medicaid plan adds prior auth requirements for mental health drugs.

And showing that not only is it a pain for everybody, but that hospitalizations and actual patient outcomes change and get worse. So there are a fair number of data points out there that validate some of the data that we’re seeing in our surveys. Emily, I want to turn to you. Can you tell us a little bit about what AMA is doing in partnership with state medical associations and especially societies at the state level?

Carroll: Absolutely. Thanks, Dr. Resneck. So inactivity on prior authorization reform grows, I think every year. And every time I talk to a state medical association, prior authorization is at the top of their advocacy agenda. I think this year alone, we saw or I have—I’m tracking at least 30 dates with prior authorization reform bills and some of those states have multiple bills. So dozens and dozens of bills this year just showing the momentum behind the need for this reform.

So first and foremost, we work with our colleagues at the state medical associations and the specialty societies working in the states to create more resources and push for prior authorization reform with them. Our Council on Legislation has created a model prior authorization reform bill that serves as a basis for a lot of the state activity going on and certainly a lot of our advocacy for what we’d like to see in state legislation.

We also create a number of issue briefs, draft testimony, data like the survey Heather’s team does every year, which is so valuable to pushing for these reforms and then information on what is happening in other states because good ideas should probably spread. We frequently engage publicly in the states as well if that’s helpful to the medical associations through letters, testifying on this issue, joint statements, really just any way we can support the physician advocates in the states on the ground.

We also really work to highlight this issue among national policy making organizations like the National Governors Association, the National Association of Insurance Commissioners, the National Council of Insurance Legislators, those sorts of groups. I think the more we engage those groups on prior authorization, the more prior authorization conversations that are happening at those meetings and among those organizations, and the more we can work prior authorization priorities into their model bills and model resources. I think that’s more momentum on this issue, that those individual policymakers can then take back to their states.

And finally, I’ll say, if any state I think that has passed prior authorization reform legislation will say—will agree with, multi-stakeholder coalitions are key. States have done amazing jobs in assembling these prior authorization coalitions of patients and hospitals, pharmacists. And we work really closely with some of those same groups at the national level building coalitions, determining what our shared priorities, activating networks when needed, et cetera.
Dr. Resneck: What are states—just in terms of trends you're seeing, can you say a bit more about what states—

Carroll: Yeah.

Dr. Resneck: --are focusing on.

Carroll: And you talked a little bit about this, Dr. Resneck. I think we're seeing a change in the landscape of prior authorization reform conversations in the states. For many years, it was about streamlining and automating this process and making it easy to do, which is still certainly a priority and should certainly still make—should certainly still be part of reform efforts.

But I think we've seen a shift recently, as you stated, that of focusing on volume reduction and really reducing those patient harms. So you brought up gold carding, which gained sort of national fame when Texas passed a gold carding bill a couple of years ago. And this idea is that—I love your analogy of a TSA Pre-check. Essentially, if you have high approval rate with a plan for a service, you get a pass on prior authorization so really reducing the volume of prior authorization for physician practices that regularly get services approved.

So the Texas law was designed to do that per service per health insurer. And since that law passed, we've seen a number of other gold carting efforts in states. This year, I think we had—there are at least 12 gold carding bills right now pending. Michigan and Louisiana have both passed gold carding bills recently. Those are more general gold carding directives to health plans. And we also have gold carting requirements in West Virginia and Vermont. And hopefully, a number of more states by the end of the year.

We've also seen uptick in legislation focusing on protections for patients with chronic conditions, as you also mentioned. We've seen a lot of bills this year and last that would reduce that repeat prior authorization for patients with chronic conditions, which would have benefited the patient you mentioned, Dr. Resneck, who was stable on a drug but had to go back for another prior authorization and ultimately got that denied initially. So really making sure that there's not that disruption in patient care when patients are stable on treatment.

We're also seeing a number of bills related to providing patients a grace period as they transition from one plan to another. So preventing a disruption in care that could happen when a new plan requires a prior authorization before a patient is allowed to access a drug or a service on their new plan. Maybe 60 days, 90 days are the trends we're seeing.

I think that's going to be really important as we anticipate a number of patients in the coming months transitioning off of Medicaid and into commercial plans, and protecting their access to care there. And then finally, I'll say we're seeing a growing interest in prior authorization data reporting.
So data on denials, approvals, appeal rates, time to decision making, et cetera. A couple of states have enacted legislation over the last couple of years and I've seen a number of bills this year that would require that information to be reported to insurance commissioners who then would have to report it to the legislature in the public. A number of other states require that information to be reported on their plan websites or in other venues.

I think these are really important requirements as it give us an insight into the black box and prior authorization. And then they also can allow us in the future to make more targeted reform efforts as we know where the pain points really are. So all these provisions and more are part of our prior authorization model bill and our principles and our policies. So we're excited to see them gaining traction in the state legislatures.

And I should say that we continue to see significant pushback on all these reforms from health plans arguing that they'll increase costs, and that prior authorization is important to managing care for patients. Dr. Resneck, I know you have done your fair share of talking to policymakers on this issue. In your experience, how do you refute those claims from insurers that prior authorization is needed to check physician prescribing or activity and have you been able to use your own personal experiences to address those false claims?

**Dr. Resneck:** It's an interesting question. Yeah, this is—one of the things that I have noticed is that the tactics of the health plans have become pretty darn predictable when we’re arguing in Congress or a state legislature about this. So inevitably, they will talk about how much money they have saved with this process. They don't then immediately mention their billions of dollars in profits or the salaries of their CEOs, but they talk about saved money.

And then they quickly turn to usually an anecdote about some surgeon out there somewhere in the country who's been doing tons of unnecessary surgeries and that they have protected patients with prior auth from this unnecessary or low quality care. So I still share anecdotes of patients who've been harmed, but I think to go beyond their anecdote versus our anecdote, one of the things that has been useful is to come armed with data.

And that comes in a couple of different versions. So some of it is very aggregate data. So having our very helpful PA survey data and the trends over the years, but again, having a validation from outsiders like the GAO report in hand is very useful. So I can't overstate the value of that.

And then some of it is personal. And so now in addition to individual stories of patients of mine, I will typically walk into one of these hearings or one of these meetings literally with, in hand, the last 10 consecutive prior auth that I did, just a notation of what they are. And in some cases, depending on the time of day of the meeting or the hearing, I will have been on my electronic health record portal on my laptop in D.C. Or wherever I've traveled to and will have been doing prior calls from my hotel room that morning.
So very—not making this up, will just—if I do nine that morning, I'll write down what the nine were for and I'll say, look, I did nine prior authors this morning. Four of them were for refills where a patient was stable with a chronic condition, three of them were for generics, one was for a nongeneric medication, but it was one where clearly the PBM is getting kickbacks for one version versus another and I'm having to change, and one was for an expensive biologic.

So here's my lived experience, and it doesn't reflect at all what you're describing you're using prior auth for. And so just validating that with those personal data can also be useful. And a lot of times, if I know which insurance company is going to be—if it's a hearing at a state level and I somebody from company x, y, or z is coming, I'll just print out my specialty—their formulary for my specialty so that I have it and I just highlight the completely ridiculous things that are nonformulary or that require prior auth.

And I'll just ask them to defend like, why is triamcinolone cream invented in the 1960s on your prior auth? This is ridiculous. This is indefensible and it's chewing up tons of our time and harming patient care, and put them on the spot. So I think those are a couple of useful things—printing out a formulary, highlighting some things on there that are ridiculous, writing down your last 10 consecutive prior auth that you actually did.

And you can—we're using medication examples, the exact same thing happens with procedures. The examples of surgeries where you don't know when you start the surgery exactly what you're going to find. You try to prior auth three possible things, you only get one of them approved. You're in somebody's belly and you find something else. For all of our specialties, we have our examples of the just completely ridiculous things that we face that make no sense. So I find that really useful.

Heather, we've had some pretty big—we mentioned the developments from CMS-related to Medicare Advantage. I had several meetings with the CMS administrator and her team. They have been just—it's been a sea-change. They've been very receptive to hearing from us and our patients about how big of a problem this is, and I really feel heard and seen and our patients being heard and seen in this room. Can you tell us a little bit more about a couple of the things that are in this proposed rule?

**McComas:** Yeah, sure. And first of all, I will just echo the sentiment of feeling heard, because all of us have been advocating for such a long time in this issue. And then to finally hear some of the concerns that we've brought forward address in rule-making, has been really exciting. So the rule that was finalized is the 2024 Part C, which is Medicare Advantage, and Part D rule.

And the prior authorization piece of that role just addresses Medicare Advantage, but some really exciting things in there. And I think the first exciting thing about this role is in the first couple characters of the long title of the role, it's CY or calendar year, contract year 2024. So these provisions go into effect at the beginning of 2024.
And throughout the rules, CMS notes that health plans and their comment said, oh, we need more time, whatever. But the government stuck with their guns and they are making changes going into effect beginning of 2024. So relief at least for Medicare Advantage is on the way. So I think that's exciting.

And then particularly on the issue of feeling heard, we see in this final rule CMS addressing prior authorization in a very holistic fashion. As Emily was talking about earlier, in recent years, the only thing that health plans, whether they are commercial or government plans, all they really wanted to talk about in terms of approving prior authorization has been automation and making things that electronic.

And again, as Emily said, we are 100% in favor of automating things and getting rid of the fax machine and phone calls, but that is not the silver bullet. I’m sure everyone in the audience realizes that is not going to magically fix everything about this process. And one of my very smart colleagues in the D.C. office, Matt Reed, came up with this phrase last year, but I think it is—really, I’d like to use it because it’s so perfect.

He said, if the underlying clinical criteria are not sound, all you’re going to accomplish with a lot prior authorization is get to an inappropriate no faster and I totally agree with that. It’s like if you have an apple and you shine it but the core is rotten, it’s still a rotten apple. So it’s really important that the clinical foundation of prior authorization programs is appropriate. And that is exactly what CMS is going after in this final rule.

To your point, they are very much responding to those very upsetting results from the Office of Inspector General. HHS report that was released last year that looked at Medicare Advantage prior authorization issues and found that in many cases, Medicare Advantage patients are not getting services that they would have gotten if they were covered by regular fee for service Medicare.

And that should not be the case, but that's what's happening right now because Medicare Advantage plans are using their internal proprietary criteria, which are obviously not appropriate because they’re not aligning with fee for service Medicare. So in this rule, CMS is saying to the MA plans, you need to follow Medicare statute regulation, local coverage determinations and national coverage determinations in your prior authorization programs.

And if there are not sufficient criteria available for Medicare, you can develop your own proprietary internal criteria, but they have to be based on, well, use treatment guidelines on clinical literature and you've got to make that information public. So I think that's really important. It's putting a light on all this. And you're going to—they're going to be showing us what clinical criteria that they are using in their prior authorization programs.

And they're also requiring a level of oversight on making these changes. Each MA plan is now going to have to have a utilization management committee that is going to make sure that these changes are
occurring and review every year and make sure that the clinical criteria are aligning with Medicare when there are existing Medicare guidelines.

And it's also important to note that the rule says that the plans cannot use prior authorization to delay or discourage care. It's really only just to be used to confirm a clinical diagnosis or to ensure that a service is medically necessary. And then one last thing—this was actually in the behavioral health part of the rule. But the rule says that an emergency medical condition can be physical or mental. And as such, behavioral health services furnished as emergency services cannot be subject to prior authorization.

And I'm sure that's obvious to all of us on this call, but I think it's really important to have it in writing. Basically, mental health emergencies are not allowed to have prior authorization. I think that's really important that the rule addressed that. And then also—and Emily mentioned that some of them have been in the states in this area, the rule also very much got into the area of continuity care when patients are switching between plans.

And Dr. Resneck, I know you brought it up over and over again what a challenge it is. A patient is stabilized on treatment and all of a sudden, they change plans and they need another prior authorization. And not only is that a huge hassle for the practice, but it disrupts the patient's treatment and their medical condition might worsen.

So the rule is going to require that MA plans have at least a 90-day transition period when patients transition between plans. And during that transition period, the plan cannot require new prior authorization and an ongoing course of treatment. It also requires that the duration of a prior authorization approval before the length of treatment, which is really important. That gets at the repetitive nature of prior authorization that Emily was highlighting.

And then finally—and this gets to the point that you just made about retroactive denials and things—you get a prior authorization and then suddenly, it gets—the claim gets denied at the end of the day. The rule says that if MA organization approves a prior authorization, they can't then deny the claim later for medical necessity reasons.

So that's really important. That's a huge issue. At the end of the day, if the claims denied, that puts the practice at huge financial risk. So a whole lot of really great things in this rule that just came out. So we're really excited to see it go into effect at the beginning of 2024.

**Dr. Resneck:** Yeah, I just love some of this content. I think as physicians, we're used to getting these prior auth procedures that at the bottom say, this is not a guarantee of payment. And I mean, I get it if the patient is no longer on the plan, but this notion that you then go and do the procedure and find out later that they've withdrawn the prior auth is ridiculous.
So I'm glad CMS is addressing that, and I love it that the rule is barring MA plans from just making up their own proprietary criteria for prior auth out of whole cloth. And if there's a national coverage determination or a local coverage determination and fee for service Medicare that says something is covered with certain criteria, then MA plans have to follow the same thing. And if there isn't one, then they actually have to use big national specialty society criteria or other similar things and they can't just make this stuff up. And you mentioned automation.

At AMA, we have been very supportive of this should be easier to file prior auth. We shouldn't be handwriting these and faxing them. We shouldn't be facing every single insurer creating their own proprietary portal that every physician has 40 more passwords. This needs to be built into our daily work, but automation alone is not enough. And sometimes I even hear health plans snickering that, yeah, if we automate this, then it'll be easier to have prior off on more things.

And so you just start spending on the hamster wheel faster and faster. So we got a question in the Q&A I see about even using AI, and I have seen some early interesting uses of AI to help create finding in the note what the health plan needs and feeding it to them. But again, we just have to reduce the number of things that are subject to this as well. Any other things, Heather, besides what's in this rule in terms of regulatory stuff happening or being considered?

**McComas:** Yeah, sure. So just to draw the line. So that rule is final. It's going into effect. Again, the government is taking a holistic approach to prior authorization. So they actually released another proposed rule late last year. The rule I'm talking about now is the CMS prior authorization and interoperability rule. This is just proposed at this point. I want to make that clear, this is not final.

But a lot of provisions in that rule also address prior authorization. A lot it leans a little bit more definitely in a technology bent the rule. It would require the impacted plans to require an electronic prior authorization process that integrates with physicians electronic health records, which is a really great thing.

And one interesting thing about this rule that makes it different from the one that we just talked about, the scope is a little bit larger in terms of the impacted plan. So it does include Medicare Advantage, which is something we actually advocated for. There was a previous iteration of this rule that came out late 2020 that did not include Medicare Advantage. So we were very happy to see that change. But it also includes Medicaid plans, Medicaid Managed Care, CHIP and CHIP Managed Care.

And then qualified health plans under the federally facilitated health care exchanges. So a bigger scope for this rule. And so these rules—these plans are beginning January 1 of 2026 or that's at least the proposal. We'll have to offer this new application programming interface technology that would, again, connect the health plan to the clinician's EHR. And it would basically be end to end automation, the prior authorization process. So really some cool stuff, if this stuff all works the way that we all hope it does.
So as the physician starts to order a service in their electronic health records, it will be hitting this API and it will say, Dr. Resneck, you need prior auth for this service. And then should you choose to proceed, it will tell you exactly what documentation you need to submit for that service to the plan. That's very helpful, bringing this welcome transparency to this process. It's not like you have to call the plan say does, this require prior authorization? So it's happening right there in your workflow, which is great.

And then the final piece is, the information is pulled from the EHR, exchanged with the health plan, the health plan comes back with a decision. So again, we overall generally think this is very promising. Again, getting the process within EHR workflow versus those proprietary portals is a big step forward. We do think that there needs to be a fair amount of testing done before this all goes live we think is a good thing.

The one negative aspect of this technology side of the proposed rule is the proposal regarding a new MIPS program promoting interoperability measure that would make sure—I see Dr. Resneck smiling. It would add a measure regarding physicians use of this electronic prior auth API technology. And we came out very strongly against this proposal and our comments, I'm sure many of the other medical organizations listening today did too.

We think that it's very counterintuitive. We're trying to reduce burden here for physicians and you're adding a MIPS requirement that requires physician practice to be tracking how much they're using this API or not using the API. I mean, it's a real reporting nightmare.

So we're very much hoping that does not go forward. And we firmly believe that this technology is really—all it's cracked up to be physicians will really want to use it, it will sell itself. There doesn't need to be this stick of a MIPS measure. So also in this rule, it's interesting there. There's a technology side, but there are also some more policy oriented proposals.

The rule does address the requirements for processing time for both urgent and regular prior authorizations. It's saying that urgent prior authorization should be completed within 72 hours, and regular prior authorization within seven days. We are directionally supportive of the fact that CMS is trying to shorten the timelines. However, we have problems with those particular numbers.

I think any of us who have ever suffered from an urgent health care problem know that 72 hours is way too long to get a prior authorization approved. My goodness. So we are urging CMS to reduce that timeline to 24 hours, which aligns with our policy. And then for regular prior authorizations, we're saying that those should be completed within 48 hours.

And we think that this piggybacks nicely with the new technology requirements being proposed because again, if this is all being automated, there's no reason that a regular prior authorization shouldn't be able to be completed within 48 hours. That's a whole promise of the technology. Another interesting thing in this role and we think it's really important and it gets, again, back to something that
Emily was mentioning, it's going to require the impacted plans to publicly report statistics about their prior authorization programs.

Things like approval rates, denial rates, overturns on appeal, and their average processing times. And we think this is really important. I think that watch behavior makes people want to do things better. And so we're really glad to see CMS proposing this. We are urging CMS to require plans to start implementing this transparency piece of the rule earlier than 2026.

We think it should go into effect immediately so that when the technology piece is in effect, we can hopefully see an improvement and a change. We think that benchmarking is really important. So hopefully, when they finalize the rule, they will make these data available sooner. And then also, the rule would require plans to provide a specific reason for denial regardless of what method is being used to process the prior authorization.

So again, another important piece of prior authorization regulation, uncertain exactly how it's going to look in its final form or when it's going to get finalized, but it's an important piece of the puzzle here.

Dr. Resneck: Wait, you mean doesn't meet criteria is not a good enough reason? Yes, it would be lovely to have some statistic.

McComas: That tells you exactly what to do. Come on.

[LAUGHTER]

There was also a very, I think, important sign on letter with all the national medical specialty societies and state medical associations on that the Part C rule. And basically, it outlined the parts of the prior authorization proposals that we supported. And CMS pretty much finalized them when they added a little bit of M but they did not scale things back despite some bellyaching on the part of health plans, so we were really excited to see the provisions go through pretty much as they had been initially proposed.

Dr. Resneck: The hours should actually include weekend hours and 48 hours shouldn't be just business days. Patients' lives and their suffering from their diseases do happen on nights and weekends as well. So an important point. We've had a couple of folks asking us about the degree to which this may eventually impact the commercial non-Medicare Advantage market, especially employer sponsored plans and ACA plans?

And our consensus document that we put out with the National Health Plans a few years ago, which unfortunately didn't lead to them following through on any of their promises to do some of this work on their own, which is why we've been seeking legislation and regulatory change.
There were some headlines where a couple of plans basically announced that they were going to voluntarily make some changes all of a sudden. I think they’re probably responding to some of this momentum in legislatures and I certainly would welcome this. I said from the beginning of that consensus document that I would go out on stage and hold hands with any plan and congratulate them for progress on this.

And I unfortunately haven’t had the opportunity to do that yet because they haven’t done the work to create that opportunity but I have to admit some skepticism about that announcement a couple of weeks ago. Emily, you probably know more about this than I do. Can you tell us about the developments that led to these news releases?

Carroll: Yeah, absolutely. And I don’t know that I do know more than you on this one because I think the details are still a little bit foggy. But UnitedHealthcare or UnitedHealthcare announced it was planning to make some changes to its prior authorization program both by significantly cutting the prior authorization requirements and also implementing a national gold carding program.

Certainly, as you said, good news. And I think to quote you, we are cautiously optimistic that these changes will actually be meaningful. But at this point, we’re still awaiting the details, and I think it will be important once we get those details to really dive into those changes and certainly monitor the implementation of those changes.

But I’ll say on its face, that is really exactly the voluntary action we were hoping to see when that consensus statement between the Insurer Trade Associations, the AMA and GMA, AHA and the pharmacists was done a number of years ago. And we certainly hope that UnitedHealthcare is not the only commercial payer that starts moving in this direction and looks to reduce the volume of prior authorization in the future based on those consensus principles that were drafted so long ago. So like I said, I think cautiously optimistic and hopeful that if it is meaningful changes, that other plans follow suit.

Dr. Resneck: We’ll remain cautiously optimistic and hopeful. Either one of you want to jump in and say anything about our grassroots campaign, FixPriorAuth, and any additional resources that we have for either physicians or patients who are in our audience?

McComas: Yeah, sure. We have a whole grassroots FixPriorAuth reform campaign, fixpriorauth.org, and it has various tracks to it. Some are oriented more towards patients, others towards physicians. We actually added an employer facing track fairly recently because again, we think that’s an important target of our advocacy messaging and trying to make the point to employers that prior authorization really might not be saving them money. It might be hurting their employees.

So all the resources that we’ve been talking about today, the survey results are on the website—are on this website. There are multiple physician videos and Dr. Resneck’s features in some of them. So I encourage you to go take a look at that as well as patient videos.
And then I think are really impactful part of this website is the story gallery. And again Dr. Resneck mentioned this before, there are stories from physicians and patients and health care professionals about how they’ve seen prior authorization impact care. And I know that these can be very helpful in advocacy work, and I know Emily, you’ve seen that be very helpful at the state legislature level and also helping with the work that’s done in the states, which is also featured on the website as well.

**Carroll:** Yeah. Just to echo that, I think the story collection page is critical. You can organize it actually by state. So you can pull stories from your specific state and use them in testimony, which I do regularly, And in other resources as you lobby your state legislatures.

Also mentioned there's a couple or a number of our state advocacy resources on that page—are on the website as well, including our model legislation and our state prior authorization law chart so you can see what's happening in the states and what has been enacted, and try and get some similar reforms enacted in your state.

**Dr. Resneck:** I just really want to emphasize how important this website has been. It's been a consistent way to communicate with the public, and actually receive these stories, which we use all the time. And so that's useful. We actually got a question it looks like maybe from a patient who's had a subsequent medical challenges and disability due to prior auth delays and wondering what they can do in addition to uploading their story, which they've already done.

And I would say, both your state policymakers and your members of Congress and your Senator, making sure that you share your stories with them so that they continue to hear about and prioritize this would be important. We got one question about the CMS rule and whether—saying it sounds like it relates to drugs, does it also apply to surgery?

And actually, just for clarification, it really deeply applies to procedures and tests. And one our—one of the bits of feedback we've given from CMS is we want more of it to apply to drugs just to make sure that we're covering both of those. But thus far, it's even primarily focused on procedures and tests. I want to turn to, can we require health plans to actually be more transparent about the cost of different alternatives? Especially if they're rejecting one thing what is the cost?

I would say—and when I think about cost, I both think about what's the patient exposure in terms of co-pay and what's the cost to the health plan if I'm going to try to be a good steward of resources? But given the incredible opacity of that whole system and the PBMs and the health plans, we almost know nothing. It used to be fairly predictable. The generic would be the cheapest alternative. That's not even predictable anymore. Heather, thoughts about progress on actually transparency around pricing?

**McComas:** Yeah, sure. So I realize this is getting a little confusing talking about the various Federal rules and what's been done and what hasn't been done yet. But the Part C and Part D rule that was finalized last week indicated there was part 2 to come. Because in the proposed version of that rule they, talked about requiring Part D prescription drug plans to support a standard transaction for real
time prescription benefit information.

And this is really important, because, Dr. Resneck, as you indicated, you just have no idea. It's like you're prescribing blind in terms of what is going to be covered and what the patient is going to have to pay. And I know you've talked before about—which is just a horrifying thought of you when finding a moment to talk to a pharmacist who will run through dummy claims to help you try to figure out what's cover. That is a huge waste of time for everybody.

So the idea is that this transaction would enable the physician, while they are e-prescribing, to ping the PBM. And it would come back and tell you if prior auth was required for this drug. It would tell you what the expected amount the patient is going to pay for that drug at the pharmacy counter so the patient pay, which is really important as you have a conversation with the patient about whether or not they can afford the medication.

And it also would indicate the plan's preferred alternatives in the same class and clinically equivalent that they prefer, as you indicated, because of their arrangements with the pharmaceutical companies. And that way, you would have a much better insight into the coverage. And so there is going to be further rule-making that will hopefully require this to go into effect. I think the proposal was that Part D plans would have to support this technology beginning January of 2025. Again, that hasn't been finalized yet.

And then the hope is that they would offer it across their books of business, not just for Part D plans. But again, that is really important. Just it's such a time suck for physicians and for pharmacists and for patients. And we know as you described earlier, it's a huge factor in treatment abandonment. Once a patient gets to the pharmacy counter and they can't pick up their medication because there is a cost issue or there's an unmet prior authorization need, they might never come back and that's just bad for everybody.

Somebody who in their community, they got together with docs and medical societies and payers and hospitals and the Department of Insurance and agreed on some prior auth reductions, but then the PBMs blocked it. And it's very hard to in these situations. There's a lot of pass the blame, I think, that goes on with health plans and PBMs as we even find this—personally, I run into it all the time at the individual patient level.

You call the PBM and they say, no, this denial is—you have to appeal to the health plan. And you call the health plan and they say, "No, no, no, it's a PBM issue." Thoughts about just the role of broader regulation that includes PBMs, how to use state insurance commissioners when this goes poorly, things beyond some of the basic model state legislation that we've looked at the state level, Emily?

Carroll: Yeah, it's a great question. And I think we can't underestimate the role of PBMs in this problem and other access issues. I think our legislation and a lot of the Bills that we're seeing in the states would apply not only to health insurers but to the PBM utilization management practices as well.
So I think that's a really critical component of state legislation, is pulling the PBMs into these reforms as well.

Health insurance commissioners at the state level are a really important resource. I think historically, insurance commissioners have maybe generally preferred outreach from patients on some of these issues. But I think there's a growing interest from those departments to hear from physicians on behalf of patients. At least most of the departments I've talked to in the last couple of years are really open to that kind of complaint and discussion.

So I really encourage patients and physicians, on behalf of their patients, to outreach to the departments. They have a lot of enforcement tools at their discretion that they can use, and they also have a lot of tools that can look at systematic issues in the state and make sure there is compliance with state law as it exists. And that they're looking at issues maybe where there isn't state law yet, but raising the alarms in some of those bad payer and PBM practices.

We've got a question about whether we have statistics available about how prior auth adds to health inequity. And I can say—I'm going to ask you guys if you know of any studies, which I don't. But my own experience is that this, like many other things in health care, falls hardest on historically marginalized communities who don't have necessarily the time and resources to fight these long fights to get their medications.

And some of the practices that also take care of those historically marginalized and minoritized communities are also some of the most overwhelmed practices in terms of being able to have the resources to hire staff to work on this. And so that's certainly been my experience. I don't know—we're about out of time, but Heather and Emily, if you've seen anything else on the intersection of this with health equity issues?

McComas: I think that's something we would love to have more concrete data. And I totally agree that certainly, the impact on those communities is exacerbated. And I think certainly, particularly to talk about patients with chronic conditions too or that are disabled, there's certainly a disproportionate impact there.

But I know all the time with my colleagues who share insurance horror stories and we always say to each other, we understand this stuff and we are having such a hard time trying to get those prioritization approved or help a family member. What is it like for someone who doesn't know the intricacies of health insurance design. And so yeah, it's really a huge challenge and it's something, I think, we hope very much hope to explore in our further research because it's an important thing to highlight in all of this.

Dr. Resneck: The hour is about up. And I want to start by thanking Emily and Heather for joining us. In my role as AMA president, I get to see behind the curtain just the incredible number of hidden gems on our advocacy team and our staff who do work that affects millions of patients, thousands of doctors
every day, but who all those folks who benefit don’t get to see.

And so you have had a chance today to see a couple of those hidden gems in our organization. And I'm glad you have had that opportunity because we’re lucky to have them. Please do visit our past AMA Advocacy Insights webinars. They’re all still available on our website and we hope you'll join us for future ones.

Until then, thank you for being here. Thank you for your engagement on prior auth, your involvement on these issues. It’s so important physicians and patients working on this really make the difference. And I’m feeling the momentum on prior auth. We got a lot of work yet to do. Thank you so much, be well, have a great rest of your week. Take care.

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