AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 811
(I-19)

Introduced by: Michigan

Subject: Require Payers to Share Prior Authorization Cost Burden

Referred to: Reference Committee J

Whereas, "Pre-authorization" takes up a significant portion of time; and

Whereas, Prior authorization remains a primarily manual, time-consuming process that often delays patient access to indicated therapy or even alters the course of therapy and places excessive burden on providers, including nurses and pharmacists, health care practices, and hospitals; and

Whereas, Prior authorization disrupts workflow and diverts valuable resources away from direct patient care; and

Whereas, Despite estimates varying by type and size of health care practice, one survey found that, on average, in United States medical practices, physicians spent three hours per week interacting with payers, nurses spent 19.1 hours, clerical staff spent 35.9 hours, and lawyers/accountants spent 7.2 hours; and

Whereas, This translates into substantial increase in uncompensated overhead health care costs; and

Whereas, A critical consequence is nonpayment if prior authorization is not obtained in advance of providing the therapy or service; and

Whereas, There are substantial costs with processing prior authorizations for nonformulary drugs on the physician office side of managed care as well as on the insurance side of the process; and

Whereas, There is some evidence that prior authorization requirements reduce non drug-related costs but little evidence that they have a positive impact on clinical or humanistic outcomes; and

Whereas, It has been found that preauthorization is a measurable burden on physician and staff time with the mean annual projected cost per full-time equivalent physician for prior authorization activities ranged from $2,161 in one study to $3,430 in another; therefore be it

RESOLVED, That our American Medical Association reaffirm policies H-320.939, "Prior Authorization and Utilization Management Reform," and H-385.951, "Remuneration for Physician Services." (Reaffirm HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 10/03/19

Sources:
1. The Journal of Cardiovascular Nursing: May/June 2017 - Volume 32 - Issue 3 - p 209-211
2. Allergy & Asthma Proceedings . Mar/Apr2006, Vol. 27 Issue 2, p119-122
3. J Manag Care Spec Pharm, 2001 Jul;7(4):297-303 4. 4. J Am Board Fam Med January 2013, 26 (1) 93-95
4. J Am Board Fam Med January 2013, 26 (1) 93-95

RELEVANT AMA POLICY

Prior Authorization and Utilization Management Reform H-320.939
1. Our AMA will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, AMA model legislation, Prior Authorization Physician Survey and other PA research, and the AMA Prior Authorization Toolkit, which is aimed at reducing PA administrative burdens and improving patient access to care.
2. Our AMA will oppose health plan determinations on physician appeals based solely on medical coding and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician.
3. Our AMA supports efforts to track and quantify the impact of health plans' prior authorization and utilization management processes on patient access to necessary care and patient clinical outcomes, including the extent to which these processes contribute to patient harm.
Citation: CMS Rep. 08, A-17; Reaffirmation: I-17; Reaffirmed: Res. 711, A-18; Appended: Res. 812, I-18; Reaffirmed in lieu of: Res. 713, A-19; Reaffirmed: CMS Rep. 05, A-19;

Remuneration for Physician Services H-385.951
1. Our AMA actively supports payment to physicians by contractors and third party payers for physician time and efforts in providing case management and supervisory services, including but not limited to coordination of care and office staff time spent to comply with third party payer protocols.
2. It is AMA policy that insurers pay physicians fair compensation for work associated with prior authorizations, including pre-certifications and prior notifications, that reflects the actual time expended by physicians to comply with insurer requirements and that compensates physicians fully for the legal risks inherent in such work.
3. Our AMA urges insurers to adhere to the AMA's Health Insurer Code of Conduct Principles including specifically that requirements imposed on physicians to obtain prior authorizations, including pre-certifications and prior notifications, must be minimized and streamlined and health insurers must maintain sufficient staff to respond promptly.
Citation: (Sub. Res. 814, A-96; Reaffirmation A-02; Reaffirmation I-08; Reaffirmation I-09; Appended: Sub. Res. 126, A-10; Reaffirmed in lieu of Res. 719, A-11; Reaffirmed in lieu of Res. 721, A-11; Reaffirmation A-11; Reaffirmed in lieu of Res. 822, I-11; Reaffirmed in lieu of Res. 711, A-14)