Reducing prior authorization burdens

Prior authorization, or the practice of insurance companies reviewing and potentially denying treatments and pharmaceuticals prescribed by a physician, remains a principal frustration for doctors and jeopardizes patient care. According to our most recent American Medical Association member survey, physicians complete an average of 33 prior authorizations per week, an administrative burden that consumes roughly two business days for doctors and administrative staff.

The AMA believes that clinical services and prescriptions covered by health insurance plans should be administered to address medically necessary conditions without delay. According to the AMA's 2019 survey, 64% of physicians and medical staff report waiting at least one day for insurance approvals while 29% of respondents claimed to wait three days for the completion of prior authorization requests.

Failure to administer medically necessary care can lead to poor health care outcomes. Most startlingly, 24% of AMA survey participants reported that prior authorization negatively affected care and led to a serious or adverse patient event, such as hospitalization, disability and permanent bodily damage, or death.

Improving prior authorization in Medicare Advantage

Congress is increasingly concerned about the negative impact of prior authorization on patients enrolled in federal health care programs. In particular, H.R. 3107, the "Improving Seniors' Timely Access to Care Act of 2019," would reduce unnecessary delays in care by streamlining and standardizing prior authorization under the Medicare Advantage program. This bipartisan bill provides crucial oversight and transparency to ensure prior authorization in Medicare Advantage doesn't negatively impact America's seniors.

More specifically, the bill would:

- Create an electronic prior authorization program, including the electronic transmission of prior authorization requests and responses, as well as a real-time process for items and services that are routinely approved
- Mandate that plans report to the Centers for Medicare & Medicaid Services on the extent they use prior authorization and their rates of approvals and denials
- Require plans to adopt transparent prior authorization programs that are reviewed annually, adhere to evidence-based guidelines, and include continuity of care for individuals transitioning between coverage policies to minimize any disruption in care
- Hold plans accountable for making timely prior authorization determinations and providing rationales for denials
- Prohibit additional prior authorization for medically necessary services performed during a surgical or invasive procedure that already received, or did not initially require, prior authorization

Urge your representative to cosponsor H.R. 3107, the "Improving Seniors' Timely Access to Care Act of 2019," or request your senators to introduce a companion bill that will reduce the burden of prior authorization within Medicare Advantage and promote patient access to timely, high-quality care.

Medical Marihuana research

The "Cannabidiol and Marihuana Research Expansion Act" (S. 2032), introduced by senators Dianne Feinstein (D-CA), Charles Grassley (R-IA) and Brian Schatz (D-HI), would improve the process for conducting scientific and clinical research on cannabidiol (CBD) and Marihuana, and streamline the development of safe and effective cannabinoid-based drugs approved by the U.S. Food and Drug Administration (FDA).

Given growing public support and legislative efforts at all levels of government to legalize the medical use of cannabis, many individuals are using Marihuana-derived products that have not been approved by the FDA. Many states and the District of Columbia have enacted laws making the medical use of cannabis legal at the state level even though such use is still illegal at the federal level.

The AMA believes that scientifically valid and well-controlled clinical trials conducted under federal investigational new drug applications are necessary to assess the safety and effectiveness of all new drugs, including potential cannabis products for medical use. Cannabis and its compounds, in particular CBD, have been found to have some therapeutic benefits. However, legal and regulatory barriers to cannabis and cannabinoid research have left physicians and patients without the evidence needed to understand the health effects of these products and make sound clinical decisions regarding their use. Our federal laws today are standing in the way of this needed research.

The AMA strongly supports the "Cannabidiol and Marihuana Research Expansion Act" to enable legitimate research evaluating the potential efficacy and safety of medicines derived from cannabis.

Urge your senator to cosponsor S. 2032, the "Cannabidiol and Marihuana Research Expansion Act," to enable medical Marihuana research, and ask your representative to introduce a companion bill in the House of Representatives.

Bipartisan telemedicine legislation: CONNECT for Health Act

The "Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act" (S. 2741/H.R. 4932), introduced by Sen. Brian Schatz (D-HI) and Rep. Mike Thompson (D-CA), would benefit Medicare beneficiaries by removing antiquated restrictions in the Medicare program that prevent physicians from using widely available medical technology that has become commonplace in the past decade.

While the medical profession, other federal health programs, state Medicaid programs and private health plans have been vigorously embracing telehealth services and technologies, Medicare coverage is restricted by law to services provided to patients who travel to certain clinical sites in rural areas. As a result, currently less than 1% of Medicare beneficiaries use telehealth services. It is long overdue that these outdated artificial barriers be removed, and that the Medicare program, beneficiaries and providers be allowed to take full advantage of innovative new telehealth services.

The "CONNECT for Health Act" would expand access to telehealth by providing the secretary of health and human services the authority to waive restrictions on payment for telehealth services, in addition to immediately authorizing Medicare to cover the use of telehealth for mental health, emergency medical services, rural health clinics and federally authorized health centers, Native American health centers, and during national emergencies, and for recertifying hospice care.

Ask your senators and representative to make modern telehealth services available to Medicare beneficiaries and physicians. Cosponsor S. 2741/H.R. 4932, the "CONNECT for Health Act."

Conrad 30 waiver program

Currently, resident physicians from other countries working in the U.S. on J-1 visas are required to return to their home country for two years after their residency has ended before they can apply for another visa or green card. The Conrad 30 program allows these physicians to remain in the U.S. without having to return home if they agree to practice in an underserved area for three years. Many communities, including rural and low-income urban districts, have problems meeting their patient care needs and depend on physicians in this program to provide health care services. With communities across the country facing physician shortages, the Conrad 30 program ensures that physicians who are often educated and trained in the U.S. can continue to provide care for patients.

Legislation is needed to reauthorize and improve the Conrad 30 waiver program to protect patient access to care in medically underserved areas.

Physician green card backlog

There is currently a sizable backlog of international medical graduates (IMGs), primarily from India and China, seeking green cards for permanent residency in the U.S. These physicians are actively practicing in the U.S. but have been waiting to receive their green cards due to a massive backlog caused by the per-country limitations imposed by law. Many of these physicians have served in the Conrad 30 program.

These IMG physicians provide important medical services to communities in need. They often choose primary care specialties and work in areas of the country with higher rates of poverty.

Not only does the backlog present a problem for physicians who are waiting on their residential status—some of whom have been waiting for several years—but workforce experts have predicted that the U.S. will face a significant physician shortage for both primary care and specialty physicians in the decade to come due to the growth of the aging population. This will disproportionately affect areas of the country that are already experiencing a physician shortage.

Patient access and Conrad 30 reauthorization legislation

S. 948/H.R. 2895, the "Conrad State 30 and Physician Access Reauthorization Act," would reauthorize and improve the Conrad 30 program by requiring more transparency in employment contract terms, creating additional waivers per states, and protecting spouses and children of physicians in the program. Further, this legislation would address the current physician green card backlog by allowing physicians who work in underserved areas or at a VA medical facility for five years to be eligible for a green card and exempt from the current per-country cap on employment-based green cards.

This legislation would help to alleviate growing physician shortages and improve patient access to care in underserved communities.

Ask your senators and representatives to support S. 948/H.R. 2895 to reauthorize and improve the Conrad 30 program, address the physician green card backlog and increase access to care in underserved communities.