AMA AMERICAN MEDICAL ASSOCIATION

Advocacy Resource Center

Advocating on behalf of physicians and patients at the state level

It is time to fix prior authorization

Prior authorization is hurting patients

- 94% of physicians report **care delays** as a result of prior authorizations.
- 79% of physicians report that prior authorization can lead to **treatment abandonment.**
- 30% of physician reported that prior authorization has led to a **serious adverse event** for their patients.
- 21% of physicians reported that prior authorization has led to a patient's **hospitalization**.
- 18% of physicians reported that prior authorization has led to a **life-threatening event or intervention to prevent permanent impairment or damage.**
- 9% of physicians report that prior authorization has led to **disability or permanent bodily damage, congenital anomaly, birth defect, or death.**

Prior authorization is costly

- Physicians and their staff spend more than 16 hours/week (two business days) on prior authorizations.
- Physicians complete an average of 40 prior authorizations per week.
- 40% of physicians have staff who work exclusively on prior authorizations.
- 86% of physicians report that the prior authorization burden has increased in the last 5 years.

What can be done?

As a start to fixing prior authorization, policymakers and other stakeholders should consider how the volume of prior authorization is impacting patients, physicians and the health care system. While these programs may reduce the amount health insurers are paying on care in the short-term, delaying or denying medically necessary care is not an appropriate or effective long-term solution to reducing costs. **Prior authorization, if used at all, must be used judiciously, efficiently, and in a manner that prevents cost-shifting onto patients, physicians and other providers.**

Policymakers should consider the following **prior authorization reforms**:

- Require public release of insurers' prior authorization data by drug and service as it relates to approvals, denials, appeals, wait times and more.
- Establish quick response times (at most, 24 hours for urgent, 48 hours for non-urgent care).
- Adverse determinations should be made only by a physician licensed in the state and of the same specialty that typically manages the patient's condition.
- Prohibit retroactive denials if care is preauthorized.
- Authorization should be valid for at least 1 year, regardless of dose changes, and for those with chronic conditions, the prior authorization should be valid for the length of treatment.
- A new plan should honor the patient's prior authorization for at least 60 days.
- Health insurers and vendors should accept and respond with the standard electronic prior authorization transaction (this does not include the use of portals for each individual payer).

For more info contact Emily Carroll, Senior Legislative Attorney, at emily.carroll@ama-assn.org.

*Data comes from the 2020 AMA Prior Authorization Physician Survey. For more information on the survey, to access prior authorization resources, and to join our grassroots campaign, visit fixpriorauth.org.