Reducing prior authorization burdens

Prior authorization—or the practice of insurance companies reviewing and potentially denying coverage of medical services and pharmaceuticals prior to treatment—remains a principal frustration for physicians and jeopardizes patient care. According to a 2024 American Medical Association survey, physicians complete an average of 39 prior authorizations per week. The administrative burden has become so acute that 40% of physician survey respondents hired staff to work exclusively on prior authorization requirements. Most alarming, however, is the fact that more than 1 in 4 physicians (29%) report that prior authorization requirements have led to a serious adverse event for a patient in their care—including hospitalization, permanent bodily damage, congenital anomalies/birth defect, or even death.

The AMA believes that medically necessary clinical services and prescriptions covered by health insurance plans should be administered without delay. Prior authorization undermines physicians' medical expertise and leads to considerable delays in patient care. According to the 2024 AMA survey, 93% of physicians reported care delays associated with prior authorization, and 82% said these requirements can lead to patients abandoning treatment.

In addition to poor clinical outcomes, prior authorization leads to increased costs due to higher overall utilization of health care resources. For example, 77% of the 2024 AMA survey respondents reported ineffectual initial treatments delivered to patients due to "step therapy (i.e., insurer mandated "fail first" requirements)," 73% reported patients requiring additional office visits, 47% reported the need to advise patients to seek urgent care or the emergency department, and 33% reported hospital admittance for patients all stemming from prior authorization. The fiscal realities raise serious questions about the overall value proposition of prior authorization.

Finally, data from the federal government further confirms the negative impact of prior authorization processes within Medicare Advantage (MA). More specifically, an April 2022 Department of Health and Human Services Office of Inspector General Report concluded that 13% of prior authorization requests that were ultimately denied for MA patients would have been approved for these same beneficiaries had they been covered under traditional Medicare. The same study also found that 18% of payment requests that were denied by MA plans actually met standard Medicare coverage and billing rules.

Improving prior authorization in Medicare Advantage

Congress remains focused on limiting the negative impact of prior authorization requirements via H.R. 3514/S. 1816, the Improving Seniors' Timely Access to Care Act. This bill reduces physician administrative burden and unnecessary delays in patient care by facilitating the expansion of electronic prior authorization solely for "items and services" in MA. The legislation, which currently has a majority of the House of Representatives (254) and a super majority of the Senate (66) as cosponsors, incorporates all major elements of a 2018 consensus statement developed by leading physician, hospital, medical group, health plan and pharmacy stakeholders.

More specifically, the bill would:

- Require MA plans to implement electronic prior authorization programs that adhere to newly developed federal standards and are capable of seamlessly integrating into electronic health systems (vs. proprietary health plan portals)
- Mandate that plans report to the Centers for Medicare & Medicaid Services (CMS) on the extent of their use of prior authorization and the rate of approvals and denials
- Provide a pathway for CMS to study and institute real-time decisions for routinely approved items and services
- Clarify CMS' authority to establish timeframes for electronic prior authorization request approvals, including expedited deadlines for emergent services
- Require HHS and other agencies to report to Congress on program integrity efforts and other ways to further improve the electronic prior authorization process

The Improving Seniors' Timely Access to Care Act passed the House of Representatives by voice vote in the 117th Congress but did not advance in the Senate due to a high Congressional Budget Office (CBO) "score" estimating significant implementation costs. H.R. 3514/S. 1816 addresses the issues that led to the high score, and its sponsors expect the CBO to estimate that the legislation will have no fiscal impact.

Congressional request

- Urge your representative/senators to cosponsor H.R. 3514/S. 1816, the Improving Seniors' Timely Access to Care Act, bipartisan, bicameral legislation that reduces the burden of prior authorization within Medicare Advantage and promotes patient access to timely, high-quality care.
- If your representative or senator has already cosponsored H.R. 3514/S. 1816, simply thank them for their support and urge them to work with bipartisan, bicameral leaders to expeditiously pass this legislation in the 119th Congress.
    - Reps. Mike Kelly (R-Pa.), Suzan DelBene (D-Wash.), Ami Bera, MD (D-Calif.), and John Joyce, MD (R-Pa.) introduced H.R. 3514, while Sens. Roger Marshall, MD (R-Kan.) and Mark Warner (D-Va.) are the lead sponsors of S. 1816.

To access the AMA's prior authorization research and advocacy resources, visit https://fixpriorauth.org/.