AMERICAN MEDICAL ASSOCIATION ORGANIZED MEDICAL STAFF SECTION

Resolution: 5
(A-25)

Introduced by: Matthew D. Gold, MD

Subject: No Prior Authorization for Inexpensive Medications

Referred to: OMSS Reference Committee
(xxxx, MD, Chair)

Whereas, a key element of American Medical Association principles is to enhance access to medical care; and

Whereas, the process known as prior authorization or preauthorization (PA) was devised for the stated purpose of restraining excessive medical care costs; and

Whereas, over time, prior authorization has increasingly been imposed on a wide spectrum of pharmaceutical and procedural medical care, including those of lower nominal cost; and

Whereas, prior authorization applied without the justification of real cost-containment can result in adverse health consequences via delay or denial of service; and

Whereas, efforts to restrain excessively intrusive prior authorization have failed to curtail such abuses by attempting to eliminate prior authorization entirely; and

Whereas, a strategy of eliminating truly nuisance application of prior authorization may be more successful; and

Whereas, a formula for determining what constitutes low cost should be devised, such as a ceiling equal to the quarterly cost of health insurance; and

Whereas, existing AMA policy already states that, “our American Medical Association advocates that low-cost noninvasive procedures that meet existing standard Medicare guidelines should not require prior authorization,” thus establishing that there should be a cost floor on the application of that process; therefore be it

RESOLVED, that our American Medical Association advocate that low-cost medications and procedures should not require prior authorization (New HOD Policy).

Fiscal Note: (Assigned by HOD)

Received: 3/18/2025

RELEVANT AMA POLICY

Insurer Accountability When Prior Authorization Harms Patients D-320.974

1. Our American Medical Association advocates for increased legal accountability of insurers and other payers when delay or denial of prior authorization leads to patient harm, including but not limited to the prohibition of mandatory pre-dispute arbitration regarding prior authorization determinations and limitation on class action clauses in beneficiary contracts.
2. Our American Medical Association advocates that low-cost noninvasive procedures that meet existing standard Medicare guidelines should not require prior authorization.
3. Our AMA supports that physicians be allowed to bill insurance companies for all full time employee hours required to obtain prior authorization.
4. Our AMA supports that patients be allowed to sue insurance carriers which preclude any and all clauses in signed contracts should there be an adverse outcome as a result of an inordinate delay in care.

Citation: Res. 711, A-24

Approaches to Increase Payer Accountability H-320.968

Our AMA supports the development of legislative initiatives to assure that payers provide their insureds with information enabling them to make informed decisions about choice of plan, and to assure that payers take responsibility when patients are harmed due to the administrative requirements of the plan. Such initiatives should provide for disclosure requirements, the conduct of review, and payer accountability.

1. Disclosure Requirements. Our American Medical Association supports the development of model draft state and federal legislation to require disclosure in a clear and concise standard format by health benefit plans to prospective enrollees of information on:
    a. Coverage provisions, benefits, and exclusions.
    b. Prior authorization or other review requirements, including claims review, which may affect the provision or coverage of services.
    c. Plan financial arrangements or contractual provisions that would limit the services offered, restrict referral or treatment options, or negatively affect the physician's fiduciary responsibility to their patient.
    d. Medical expense ratios.
    e. Cost of health insurance policy premiums. (Ref. Cmt. G, Rec. 2, A-96; Reaffirmation A-97)
2. Conduct of Review. Our AMA supports the development of additional draft state and federal legislation to:
    a. Require private review entities and payers to disclose to physicians on request the screening criteria, weighting elements and computer algorithms utilized in the review process, and how they were developed.
    b. Require that any physician who recommends a denial as to the medical necessity of services on behalf of a review entity be of the same specialty as the practitioner who provided the services under review.
    c. Require every organization that reviews or contracts for review of the medical necessity of services to establish a procedure whereby a physician claimant has an opportunity to appeal a claim denied for lack of medical necessity to a medical consultant or peer review group which is independent of the organization conducting or contracting for the initial review.
    d. Require that any physician who makes judgments or recommendations regarding the necessity or appropriateness of services or site of service be licensed to practice medicine in the same jurisdiction as the practitioner who is proposing the service or whose services are being reviewed.
    e. Require that review entities respond within 48 hours to patient or physician requests for prior authorization, and that they have personnel available by telephone the same

business day who are qualified to respond to other concerns or questions regarding medical necessity of services, including determinations about the certification of continued length of stay.

f. Require that any payer instituting prior authorization requirements as a condition for plan coverage provide enrollees subject to such requirements with consent forms for release of medical information for utilization review purposes, to be executed by the enrollee at the time services requiring such prior authorization are recommended or proposed by the physician.

g. Require that payers compensate physicians for those efforts involved in complying with utilization review requirements that are more costly, complex and time consuming than the completion of standard health insurance claim forms. Compensation should be provided in situations such as obtaining preadmission certification, second opinions on elective surgery, and certification for extended length of stay.

3. Accountability. Our AMA believes that draft federal and state legislation should also be developed to impose similar liability on health benefit plans for any harm to enrollees resulting from failure to disclose prior to enrollment the information on plan provisions and operation specified under Section 1 (a)-(d) above.

Citation: Issued: BOT Rep. M, I-90; Reaffirmed: Res. 716, A-95; Reaffirmed: CMS Rep. 4, A-95; Reaffirmed: I-96; Reaffirmed: Rules and Cred. Cmt, I-97; Reaffirmed: CMS Rep. 13; I-98; Reaffirmed: I-98; Reaffirmed:A-99; Reaffirmation: I-99; Reaffirmed: A-00; Reaffirmed in lieu of: Res. 839, I-08; Reaffirmed: A-09; Reaffirmed: Sub. Res. 728, A-10; Modified: CMS Rep. 4, I-10; Reaffirmed: A-11; Reaffirmed in lieu of Res. 108, A-12; Reaffirmed: Res. 709, A-12; Reaffirmed; CMS Rep. 07, A-16; Reaffirmed in lieu of: Res. 242, A-17; Reaffirmed in lieu of: Res. 106, A-17; Reaffirmed: A-17; Reaffirmed: A-18; Reaffirmed: A-19; Reaffirmed: Res. 206, I-20; Reaffirmed: A-22; Modified: Speakers Rep. 02, I-24

Promoting Accountability in Prior Authorization D-285.960

1. Our American Medical Association will advocate that peer-to-peer (P2P) prior authorization (PA) determinations must be made and actionable at the end of the P2P discussion notwithstanding mitigating circumstances, which would allow for a determination within 24 hours of the P2P discussion.
2. Our AMA will advocate that the reviewing P2P physician must have the clinical expertise to treat the medical condition or disease under review and have knowledge of the current, evidence-based clinical guidelines and novel treatments.
3. Our AMA will advocate that P2P PA reviewers follow evidence-based guidelines consistent with national medical specialty society guidelines where available and applicable.
4. Our AMA will continue to advocate for a reduction in the overall volume of health plans' PA requirements and urge temporary suspension of all PA requirements and the extension of existing approvals during a declared public health emergency.
5. Our AMA will advocate that health plans must undertake every effort to accommodate the physician's schedule when requiring peer-to-peer prior authorization conversations.
6. Our AMA will advocate that health plans must not require prior authorization on any medically necessary surgical or other invasive procedure related or incidental to the original procedure if it is furnished during the course of an operation or procedure that was already approved or did not require prior authorization.

Citation: CMS Rep. 4, A-21