AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: (Assigned by HOD)
(I-26)

Introduced by: Private Practice Physicians Section

Subject: Due Process, Transparency, and Accountability for Delegated Third-Party Prior Authorization and Utilization Management Entities

Referred to: Reference Committee (Assigned by HOD)

Whereas, health insurers increasingly delegate prior authorization (PA) and utilization management (UM) determinations to third-party vendors such as EviCore (now part of Evernorth, a Cigna subsidiary), which issues coverage recommendations for advanced imaging, oncology, cardiology, pain management, and other services on behalf of more than 100 insurers whose plans cover approximately 100 million Americans; and

Whereas, these delegated UM entities are retained and compensated by health plans — not by patients, plan enrollees, or treating physicians — and therefore owe no contractual duty, fiduciary obligation, or professional accountability to the patient whose care they adjudicate or to the physician who ordered it; and

Whereas, investigative reporting has documented that such entities market their services to insurers on the promise of a return on investment as high as 3-to-1 — three dollars in reduced medical spending for every dollar of vendor fees — creating a direct financial incentive to deny rather than approve medically necessary care; and

Whereas, that same reporting describes proprietary algorithmic controls, referred to internally as "the dial," which can be adjusted to raise or lower the proportion of requests routed for manual clinical review, permitting effective denial rates to be calibrated to financial targets rather than to clinical evidence or patient need; and

Whereas, peer-reviewed appraisal of one such entity's advanced diagnostic imaging guidelines for the spine found material departures from national medical specialty society recommendations and the published evidence base, and the HHS Office of Inspector General has repeatedly found that Medicare Advantage organizations deny prior authorization requests that meet Medicare coverage rules, with denials overturned on appeal at very high rates; and

Whereas, AMA Policy H-480.940 calls for insurer use of augmented intelligence in claims and prior authorization review to include review by physicians "with no incentive to deny care," and AMA Policy H-320.939 calls for adverse determinations to be reviewed directly by a physician of the same medical specialty or subspecialty as the ordering physician, yet no federal requirement operationalizes either standard when review has been delegated to a financially interested third-party entity; and

Whereas, AMA Policy H-285.939 establishes that utilization review decisions to deny payment for medically necessary care constitute the practice of medicine and that medical directors of insurance entities must be held accountable and liable for those decisions, but delegation to a third-party entity allows a health plan to place its own medical director beyond the reach of the treating physician while retaining the coverage decision; and

Whereas, existing federal frameworks — the ERISA claims procedure regulation at 29 CFR 2560.503-1, the Affordable Care Act internal appeals and external review requirements, the Medicare Advantage utilization management rules at 42 CFR Part 422 Subpart M as strengthened by CMS-4201-F, and the Interoperability and Prior Authorization Final Rule (CMS-0057-F) — govern the plan's obligations but do not require a plan to make its own medical director available for peer-to-peer review following a delegated adverse determination, do not require disclosure of the financial terms of delegated UM contracts, and do not prohibit compensation contingent on denial or savings targets; therefore be it

RESOLVED, that our American Medical Association advocate for federal legislation and/or regulation requiring that, whenever a delegated third-party utilization management entity issues an adverse determination denying, reducing, or terminating requested care, the health plan make its own medical director — licensed in the state in which the patient is receiving care and of the same specialty or subspecialty as the ordering physician — directly available to the treating physician for peer-to-peer review, and that the health plan's medical director, rather than the delegated entity's reviewer, bear final accountability for the coverage determination (Directive to Take Action); and be it further

RESOLVED, that our AMA will advocate for federal legislation and/or regulation when appropriate, irrespective of contract type, requiring health plans and their delegated utilization management entities to publicly disclose the material financial terms of their utilization management contracts, in particular whether any portion of compensation is contingent upon or proportional to denial rates, cost-savings targets, or return-on-investment guarantees (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for federal legislation and/or regulation establishing that delegated third-party utilization management entities and their clinical reviewers are subject to the same accountability standards applicable to health plan medical directors under AMA Policy H-285.939, and that the contracting health plan remain jointly accountable for adverse determinations issued on its behalf (Directive to Take Action).

Fiscal Note: (Assigned by HOD)

References:

1. Rucker P, Miller M, Armstrong D. "Not Medically Necessary: Inside the Company Helping America's Biggest Health Insurers Deny Coverage for Treatments Doctors Recommend." ProPublica. October 23, 2024. https://www.propublica.org/article/evicore-health-insurance-denials-cigna-unitedhealthcare-aetna-prior-authorizations
2. Bukowiec L, Stahl B, Imam N, et al. A critical appraisal of EviCore's guidelines for advanced diagnostic imaging of the spine for lower extremity pain with neurological features. J Spine Surg. 2023;9(1). PMCID: PMC10082428.
3. U.S. Department of Health and Human Services, Office of Inspector General. Reports on the use of prior authorization and denials of medically necessary care in Medicare Advantage. https://oig.hhs.gov/reports-and-publications/
4. American Medical Association. 2024 AMA Prior Authorization Physician Survey. https://www.ama-assn.org/system/files/prior-authorization-survey.pdf

5. American Medical Association. “AMA adopts policy calling for more oversight of AI in prior authorization.” June 14, 2023. https://www.ama-assn.org/press-center/ama-press-releases/ama-adopts-policy-calling-more-oversight-ai-prior-authorization
6. Centers for Medicare & Medicaid Services. CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F), 89 Fed. Reg. 8758 (February 8, 2024). https://www.cms.gov/priorities/key-initiatives/burden-reduction/interoperability/policies-and-regulations/cms-interoperability-and-prior-authorization-final-rule-cms-0057-f
7. Centers for Medicare & Medicaid Services. Medicare Advantage Utilization Management Requirements, 42 CFR Part 422, Subpart M, as amended by CMS-4201-F, 88 Fed. Reg. 22120 (April 12, 2023).
8. U.S. Department of Labor. ERISA Claims Procedure Regulation, 29 CFR 2560.503-1. https://www.ecfr.gov/current/title-29/section-2560.503-1

RELEVANT AMA POLICY

Managed Care Medical Director Liability H-285.939

AMA policy is that utilization review decisions to deny payment for medically necessary care constitute the practice of medicine. Our AMA seeks to include in federal and state patient protection legislation a provision subjecting medical directors of managed care organizations to state medical licensing requirements, state medical board review, and disciplinary actions; that medical directors of insurance entities be held accountable and liable for medical decisions regarding contractually covered medical services; and that our AMA continue to undertake federal and state legislative and regulatory measures necessary to bring about this accountability.

Citation: Sub. Res. 202, A-98; Appended: Res. 201, I-98; Reaffirmation A-99; Reaffirmed: BOT Rep. 18, I-00; Reaffirmation A-07; Reaffirmed in lieu of Res. 235, A-11; Reaffirmed: BOT Rep. 7, A-21; Reaffirmed: CMS Rep. 4, A-21.

Prior Authorization and Utilization Management Reform H-320.939

Our AMA will continue its widespread prior authorization advocacy and outreach; 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; supports efforts to track and quantify the impact of health plans' prior authorization and utilization management processes on patient access and clinical outcomes, including the extent to which these processes contribute to patient harm; and will advocate for health plans to minimize burden when updates must be made to previously approved and/or pending prior authorization requests.

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; Reaffirmed: Res. 811, I-19; Reaffirmed: CMS Rep. 4, A-21; Appended: CMS Rep. 5, A-21; Reaffirmation: A-22.

Medical Necessity and Utilization Review H-320.942

Our AMA supports efforts to ensure medical necessity and utilization review decisions are based on established and evidence-based clinical criteria to promote the most clinically appropriate care.

Citation: Res. 810, I-16; Reaffirmation: A-18; Reaffirmation: A-22.

Utilization Review, Medical Necessity Determination, Prior Authorization Decisions D-320.977

Our AMA will advocate for implementation of a federal version of a prior authorization “gold card” law, and that health plans should offer physicians at least one physician-driven, clinically-based alternative to prior authorization.

Citation: Res. 727, A-22; CEJA Rep. 01, A-23.

Augmented Intelligence in Health Care H-480.940

Our AMA will advocate for greater regulatory oversight of insurers’ use of augmented intelligence for review of patient claims and prior authorization requests, including that the process be based on accurate and up-to-date clinical criteria, include review by physicians and other health care professionals with expertise for the service under review and no incentive to deny care, and require human examination of patient records prior to a care denial.

Citation: BOT Rep. 41, A-18; Appended: A-23; Reaffirmed: CMS Rep. 07, A-24; Reaffirmed: CSAPH Rep. 08, A-25.