

# 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 2021 American Medical Association (AMA) survey, physicians complete an average of 41 prior authorizations per week, an administrative burden that consumes nearly two business days of physician and staff time. The burden has become so acute that 40% of physician survey respondents hired staff to work exclusively on prior authorization requirements.

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 2021 survey, 93% of physicians reported care delays associated with prior authorization, and 82% said these requirements can at least sometimes lead to patients abandoning treatment.

Failure to administer medically necessary care can lead to poor health care outcomes. Most startlingly, 34% of AMA survey participants reported that prior authorization led to a serious adverse event, such as hospitalization, disability and permanent bodily damage, or death, for a patient in their care.

### **Improving prior authorization in Medicare Advantage**

Since Congress is increasingly concerned about the negative impact of prior authorization on patients and physicians within federal health care programs, a bipartisan collection of House and Senate lawmakers introduced H.R. 3173/S. 3018, the Improving Seniors' Timely Access to Care Act. This bill reduces unnecessary delays in care by streamlining and standardizing prior authorization under the Medicare Advantage program. In addition, the legislation, which currently has more than 320 bipartisan cosponsors in both the House and Senate, 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 Medicare Advantage 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), as well as establish real-time decision-making processes for items and services that are routinely approved.
- Mandate that plans report to the Centers for Medicare & Medicaid Services on the extent of their use of prior authorization and the rate of approvals and denials.
- Require plans to adopt transparent prior authorization programs that are reviewed annually, adhere to evidence-based guidelines, permit gold carding, and include continuity of care for individuals transitioning between coverage policies to minimize any care disruptions.
- Hold plans accountable for making timely prior authorization determinations and providing rationales for denials.

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**Thank your representatives for the overwhelming bipartisan House vote; the bill passed by voice vote on September 14, and now moves to the Senate. Urge your senators to cosponsor S. 3018, 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.**

To access the AMA's prior authorization research and advocacy resources, visit [ama-assn.org/prior-auth](http://ama-assn.org/prior-auth).