Prior authorization (PA) is a health plan cost-control process that requires health care professionals to obtain advance approval from the health plan before a prescription medication or medical service qualifies for payment and can be delivered to the patient. While health plans and benefit managers contend PA programs are necessary to control costs, physicians and other providers find these programs to be time-consuming barriers to the delivery of necessary treatment.

To assess the ongoing impact the PA process has on patients, physicians, employers and overall health care spending, the American Medical Association (AMA) annually conducts a nationwide survey of 1,000 practicing physicians (400 primary care/600 specialists) from a wide range of practice settings. As this year’s findings demonstrate, the PA process continues to have a devastating effect on patient outcomes, physician burnout and employee productivity. In addition to negatively impacting care delivery and frustrating physicians, PA is also leading to unnecessary spending (e.g., additional office visits, unanticipated hospital stays and patients regularly paying out-of-pocket for care).

### Care delays associated with PA

**Q:** For those patients whose treatment requires PA, how often does this process delay access to necessary care?

- Always (0%)
- Often
- Sometimes
- Rarely (5%)
- Never (0%)
- Don’t know (1%)

94% report care delays

### Treatment abandonment due to PA

**Q:** How often do issues related to the PA process lead to patients abandoning their recommended course of treatment?

- Always (0%)
- Often
- Sometimes
- Rarely
- Never (1%)
- Don’t know (1%)

78% report that PA can at least sometimes lead to treatment abandonment

### Impact of PA on clinical outcomes

**Q:** For those patients whose treatment requires PA, what is your perception of the overall impact of this process on patient clinical outcomes?

- Somewhat or significant negative impact
- No impact
- Somewhat or significant positive impact (1%)

More than 1 in 3 physicians (35%) report that PA criteria are rarely or never evidence-based

- 19% of physicians report that PA has led to a patient’s hospitalization
- 13% of physicians report that PA has led to a life-threatening event or required intervention to prevent permanent impairment or damage
- 7% of physicians report that PA has led to patient’s disability/ permanent bodily damage, congenital anomaly/birth defect or death
On average, practices complete **43 PAs** per physician, per week.

Physicians and their staff spend **12 hours** each week completing PAs.

More than **1 in 3 or 35%** of physicians have staff who work exclusively on PA.

### PA denials

**More than 1 in 4 (27%)** physicians report that PAs are often or always denied.

Q: How has the number of PA denials changed over the last five years?

- Increased somewhat or significantly: 21%
- No change: 73%
- Decreased somewhat or significantly: 6%
- Don't know: 3%

### PA appeals

**Fewer than 1 in 5 (18%)** physicians report that they always appeal an adverse PA decision.

Q: Why don’t physicians appeal?

- Report that they do not believe the appeal will be successful based on past experience: 62%
- Report that patient care cannot wait for the health plan to approve the PA: 48%
- Report that they have insufficient practice staff resources/time: 48%

When navigating the PA process, especially when appealing an adverse health plan PA decision, physicians are often required to participate in a “peer-to-peer (P2P) review” with a health plan representative. In fact, almost two out of three physicians (61%) report at least sometimes having to participate in P2P reviews.

P2P reviews require the physician to speak directly with a health plan representative, disrupting patient appointments and consuming significant physician time. As the findings demonstrate, the frequency of P2Ps is increasing, and physicians often do not speak to an appropriately qualified “peer.”

Q: How has the frequency of peer-to-peer reviews during the PA process changed over the last five years?

- Increased significantly: 39%
- Increased somewhat: 37%
- No change: 17%
- Decreased somewhat: 6%
- Decreased significantly: 2%

Percentages do not sum to 100% due to rounding.

Q: How often does the health plan’s “peer” have the appropriate qualifications to assess and make a determination regarding the PA request?

- Always: 32%
- Often: 35%
- Sometimes: 14%
- Rarely: 6%
- Never: 12%
- Don’t know: 2%

Percentages do not sum to 100% due to rounding.

*Percentages sum to 15% due to rounding.

Physician impact

PA leads to substantial administrative burdens for physicians, taking time away from direct patient care, costing practices money and significantly contributing to physician burnout. PA undercuts the financial stability of physician practices that are already struggling to stay solvent in this time of dwindling Medicare payments.

95% of physicians report that PA somewhat or significantly increases physician burnout.

Q: How often do physicians appeal an adverse PA decision when they are required to participate in a peer-to-peer (P2P) review?

- Always: 62%
- Often: 48%
- Sometimes: 14%
- Rarely: 6%
- Never: 2%
- Don’t know: 2%

Percentages do not sum to 100% due to rounding.

Q: How often do physicians appeal an adverse PA decision when they are required to participate in a peer-to-peer (P2P) review?

- Always: 62%
- Often: 48%
- Sometimes: 14%
- Rarely: 6%
- Never: 2%
- Don’t know: 2%

Percentages do not sum to 100% due to rounding.

Q: How often do physicians appeal an adverse PA decision when they are required to participate in a peer-to-peer (P2P) review?

- Always: 62%
- Often: 48%
- Sometimes: 14%
- Rarely: 6%
- Never: 2%
- Don’t know: 2%

Percentages do not sum to 100% due to rounding.

Q: How often do physicians appeal an adverse PA decision when they are required to participate in a peer-to-peer (P2P) review?

- Always: 62%
- Often: 48%
- Sometimes: 14%
- Rarely: 6%
- Never: 2%
- Don’t know: 2%

Percentages do not sum to 100% due to rounding.

Q: How often do physicians appeal an adverse PA decision when they are required to participate in a peer-to-peer (P2P) review?

- Always: 62%
- Often: 48%
- Sometimes: 14%
- Rarely: 6%
- Never: 2%
- Don’t know: 2%

Percentages do not sum to 100% due to rounding.

Q: How often do physicians appeal an adverse PA decision when they are required to participate in a peer-to-peer (P2P) review?

- Always: 62%
- Often: 48%
- Sometimes: 14%
- Rarely: 6%
- Never: 2%
- Don’t know: 2%

Percentages do not sum to 100% due to rounding.

Q: How often do physicians appeal an adverse PA decision when they are required to participate in a peer-to-peer (P2P) review?

- Always: 62%
- Often: 48%
- Sometimes: 14%
- Rarely: 6%
- Never: 2%
- Don’t know: 2%

Percentages do not sum to 100% due to rounding.

Q: How often do physicians appeal an adverse PA decision when they are required to participate in a peer-to-peer (P2P) review?

- Always: 62%
- Often: 48%
- Sometimes: 14%
- Rarely: 6%
- Never: 2%
- Don’t know: 2%

Percentages do not sum to 100% due to rounding.

Q: How often do physicians appeal an adverse PA decision when they are required to participate in a peer-to-peer (P2P) review?

- Always: 62%
- Often: 48%
- Sometimes: 14%
- Rarely: 6%
- Never: 2%
- Don’t know: 2%

Percentages do not sum to 100% due to rounding.

Q: How often do physicians appeal an adverse PA decision when they are required to participate in a peer-to-peer (P2P) review?

- Always: 62%
- Often: 48%
- Sometimes: 14%
- Rarely: 6%
- Never: 2%
- Don’t know: 2%

Percentages do not sum to 100% due to rounding.
What is the cost of PA?

Not only does PA negatively impact patient care and significantly contribute to physician frustration and burnout, it also adds significant costs to the entire health care system. For example, patients are often forced to try ineffective treatments and/or schedule additional office visits because of PA requirements and delays. These delays inevitably lead patients to seek more expensive forms of care, including emergency room visits, and can even lead to unexpected hospitalization.

Q: Please consider how your patients’ utilization of health care resources is impacted by the PA process. In your experience, how often does the PA process lead to higher overall utilization of health care resources?

- Always: 6%
- Often: 39%
- Sometimes: 42%
- Rarely: 10%
- Never (1%)
- Don’t know (2%)

87% report that PA leads to higher overall utilization.

Q: In which of the following ways has the PA process led to higher overall utilization of health care resources for patients in your care?

- Ineffective initial treatment (e.g., due to step therapy requirements): 69%
- Additional office visits: 68%
- Immediate care/ER visits: 42%
- Hospitalizations: 29%

In addition to higher health care resource utilization, PA can lead to other negative financial impacts for both employers and patients. Employers may face reduced productivity if PA causes employees to miss work due to rescheduled appointments or continued illness while waiting for care. In other situations, patients may pay out of pocket rather than endure PA-related care delays. Both scenarios raise serious questions about the overall value proposition of PA.

Patient out-of-pocket costs and PA

Q: How often does a PA delay or denial lead to a patient paying out of pocket for a medication that you prescribe (i.e., the health plan does not cover the prescription and the patient pays the full cost)?

- Always (1%)
- Often: 20%
- Sometimes: 17%
- Rarely: 58%

79% report that the PA process at least sometimes leads patients to pay out of pocket for a medication.

Employer impact

53% of physicians with patients in the workforce report that PA has impacted patient job performance.
Health plan PA performance

To reduce administrative burdens and promote access to safe, timely care, the AMA, along with the American Hospital Association, American Pharmacists Association, Medical Group Management Association, America’s Health Insurance Plans, and Blue Cross Blue Shield Association, released the “Consensus Statement on Improving the Prior Authorization Process” (CS) in January 2018. Unfortunately, despite being released nearly six years before this survey was fielded, physicians report that health plans have made little progress honoring their commitments as outlined in the CS.

Several national insurers announced plans to voluntarily reduce the number of services that require PA in 2023. However, despite these claims and the commitments made in the CS, physicians report consistently high PA burdens across major health plans.

Q: How would you describe the burden associated with PA in your practice for the following health plans?

Survey methodology

- Forty-question, web-based survey administered in December 2023
- Sample of 1,000 practicing physicians drawn from Medscape panel
- Forty percent primary care physicians/60% specialists
- Sample screened to ensure that all participating physicians:
  - Are currently practicing in the United States
  - Provide 20+ hours of patient care per week
  - Complete PAs during a typical week of practice
- Complete survey questions can be found here [link]

References

2. “2 big insurers take small steps to ease prior authorization burden” available at: [link]