

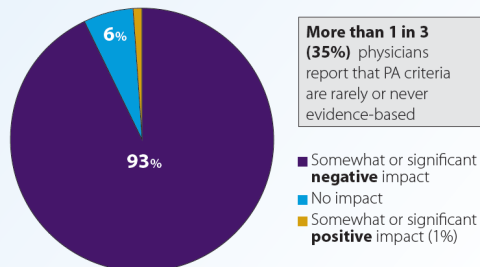
Rein in Prior Authorization Requirements

The Problem

Prior authorization is a significant barrier to care and negatively impacts outcomes.

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?



The Issue

Prior authorization (PA) is an insurance company cost-control mechanism that requires healthcare providers to obtain advance approval before a medication or treatment qualifies for payment and can be delivered to the patient. In 2023, Medicare Advantage (MA) insurers fully or partially denied 3.2 million prior authorization requests. A recent Inspector General report found that 13% of the prior-authorization requests denied by MA plans met traditional Medicare rules.

While health plans contend PA helps control costs, these requirements are often time-consuming barriers to treatment. In a survey by the American Medical Association, 94% of physicians reported that PA delays care and 78% said that patients sometimes abandon care due to PA hurdles.

Finally, PA imposes substantial administrative burdens on physicians and take time away from direct patient care, cost practices money, and strongly contribute to physician burnout. PA guidelines should be transparent, predictable, evidence-based, and based on input from practicing physicians.

The Solutions

Cosponsor legislation to rein in prior authorization:

Improving Seniors Timely Access to Care Act (Sens. Marshall/Warner) streamlines PA in Medicare Advantage plans, sets standards and increases transparency.

Reducing Medically Unnecessary Delays in Care Act (Rep. Mark Green) requires written guidelines, and requires that prior authorizations be reviewed by specialists in the same field as the requesting physician.

Facts

1 in 4

physicians report that PA has led to serious adverse events for patients

95%

of physicians report that PA increases provider burnout