Fixing prior auth: First, speed up payers' response times

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The time-wasting, care-delaying, insurance company cost-control process known as prior authorization has gone from a rarely employed tool to discourage use of extremely pricey interventions to a form of utilization management that comes as naturally to payers as breathing does to the rest of us.

Prior authorization is overused, and existing processes present significant administrative and clinical concerns. That is why fixing prior authorization is a critical component of the AMA Recovery Plan for America's Physicians.

Like Hydra of Greek mythology, prior authorization is a multiheaded monster that is difficult to kill. One head is characterized by slugging response times, another by an overwhelming and increasing volume of requirements, yet another by inadequate peer-to-peer reviews—and there's more. As the physician's powerful ally in health care, the AMA is tackling prior authorization with research, practice tools and reform resources.

That requires attacking every head of prior authorization's horrendous Hydra, as outlined in this AMA article series on fixing prior auth. We begin with the clear imperative to speed up prior authorization responses from health insurance companies on prior authorization requests.

What's the problem?

Physicians are forced to seek prior authorization from payers so they can provide the care their training and experience tells them their patients need, but they don't often get a yes or no answer quickly. That lag time results in real harm to patients.

Kathleen Valentini is an extreme example of what can happen when care is delayed. While cancer led to her death, prior authorization shares the blame. The New York woman had crucial medical care delayed while she waited for prior authorization from eviCore, a third-party administrator that her health plan contracted with for prior authorization reviews.

EviCore's slow response resulted in a delay in Valentini's cancer being detected. In turn, that took away the possibility of her having a chemotherapy treatment option that was less radical, and possibly more effective. It also resulted in pain for Valentini. She had her leg, hip and pelvis amputated before she ultimately died.

During a webinar hosted by KFF, radiation oncologist Fumiko Chino, MD, said that when she thinks about the burden of prior authorization in cancer care, "it's not just for cancer treatments. It's even for things like pain medication." And it can lead to moral distress.

"When you are having to talk to someone who is having uncontrolled pain and your hands are tied due to prior authorization, it's leading to increased burnout, ultimately affecting the patients in negative ways and the physician workforce," said Dr. Chino, whose research on cancer patients' experiences with prior auth was published in *JAMA Network Open*.

Having to wait for care or medication that their physicians said they needed because of prior authorization delays has resulted in unnecessary pain, the worsening of patients' illnesses and in some cases even death.

One-third of the 1,001 physicians the AMA surveyed (PDF) reported that prior authorization has led to a serious adverse event for a patient in their care. These shares of the physician reported that prior authorization led to:

- A patient's hospitalization—25%.
- A life-threatening event or one that required intervention to prevent permanent impairment or damage—19%.
- A patient's disability or permanent bodily damage, congenital anomaly or birth defect, or death— 9%.

Survey data from 2022 has found that 94% of patients reported care delays associated with prior authorization.

Similarly, when the Arthritis Foundation surveyed more than 3,000 patients, it found that three days was the average wait time for prior authorization. However, 31% of respondents said they had waited more than a week for an answer.

And AMA data (PDF) shows that problems with prior authorization response times haven't gotten any better.

What are the fixes?

Federal and state lawmakers and regulators need to enact policy changes to ensure that patients and physicians get timely answers to prior authorization requests.

Specifically, the AMA is calling for laws to require payers or their third-party administrators in nonurgent care situations to make a determination about care and notify the physician or other health professional within 48 hours of obtaining all of the necessary information. In urgent care situations, they should make the determination and notify the provider within 24 hours.

What progress has been made?

Some states have passed laws (PDF) that address the time frame in which payers must respond to prior authorization requests. For example, Arkansas requires responses for nonurgent cases within two business days of receiving all of the necessary information; answers must be given within one business day in urgent cases. Colorado, meanwhile, requires an answer in one business day for urgent situations and Washington, D.C., requires a response within 24 hours for urgent requests.

At the federal level, earlier this year the Centers for Medicare and Medicaid Services (CMS) issued a final rule that will, among other things, require payers to send prior authorization decisions within 72 hours for urgent requests and within a week for nonurgent requests—starting in 2026.

While that is longer than the time frame the AMA and others are calling for, CMS noted that it represents a 50% improvement for some payers. The rule will apply to these government-regulated health plans:

Medicare Advantage; State Medicaid and Children's Health Insurance Program (CHIP) fee-for-service programs; Medicaid managed care plans and CHIP managed care entities; and qualified health plan issuers on the federally facilitated exchanges.

In the years before that final rule, the AMA was part of a working group that created the "Prior Authorization and Utilization Reform Principles" (PDF) that includes 21 principles covering five main areas, including timely access and administrative efficiency. One principle specifically calls for a 48-hour turnaround on nonurgent determinations and 24-hour turnaround in urgent situations.

The principles ultimately led to a 2018 consensus statement (PDF) with the Blue Cross Blue Shield Association, Medical Group Management Association, America's Health Insurance Plans and others that included an agreement to "timely notification of prior authorization determinations by health plan

to impacted health care providers (both ordering/rendering physicians and dispensing pharmacists) and patients/enrollees."

Despite that agreement, payers have largely dragged their feet on speeding up the slow prior authorization request response times that delay care and endanger patients' health.

What's the AMA still pushing for?

To protect patient safety, the AMA continues to lobby for state and federal legislation and rules that would set a 24-hour time limit for responses in urgent cases and a 48-hour time limit in nonurgent cases.

AMA CEO and Executive Vice President James L. Madara, MD, wrote in a letter to the CMS administrator (PDF) that the failure to provide timely prior auth decisions "can literally mean life or death for patients," as physicians have reported in surveys. The letter urges CMS to "shorten these time frames to protect patient health and safety," stating that "when care is urgent, 72 hours is simply not a safe amount of time to wait to receive approval for coverage."

How can patients and physicians help?

An AMA model bill (PDF) can help physicians get started on advocating change in their own state legislatures. Patients, doctors and employers can learn more about reform efforts and share their personal experiences with prior authorization at FixPriorAuth.org.

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